

Chapter: Medical Services (MD)

Section 10: Withholding Resuscitative Services

Policy

Utah State Hospital is a level four emergency care provider. Acute and stable chronic physical illnesses are managed by Medical Services. Life threatening emergencies occurring at Utah State Hospital are referred to a level one emergency care provider for evaluation and treatment. Utah State Hospital recognizes that adult (18 years and older) patients who have not been deemed incompetent have the right to refuse life-sustaining procedures, which may include resuscitative procedures, by executing an advance directive.

Definitions

1. Life-Threatening Condition: is an underlying condition in which death is imminent, unless the underlying cause is corrected, and in which resuscitation may be required to sustain life.
2. Cardiopulmonary Arrest: is the sudden cessation of circulation, respiration, or both, and is a terminal event unless quick and efficient cardiopulmonary resuscitation is administered.
3. Cardiopulmonary Resuscitation: includes medical therapies provided promptly and appropriately to restore respiration, circulation, or both following a cardiopulmonary arrest. Such therapies include artificial ventilation via mouth-to-pocket mask or use of Ambu bag, chest compressions, and the actions of a cardiopulmonary resuscitation (CPR) team. Pocket masks or Ambu bags are available in all patient areas and at the switchboard in the Heninger Administration Building. Mouth-to-mouth resuscitation is not considered standard procedure.
4. Terminal Condition: is a condition caused by injury, disease, or illness, which regardless of the application of life-sustaining procedures, would within reasonable medical judgment produce death, and where the application of life-sustaining procedures would serve only to postpone the moment of death.

Procedure

1. Patients Requesting that Resuscitation be Withheld: Utah State Hospital recognizes that all adult patients who have not been deemed incompetent have the right to execute an advance directive stating treatment they would desire or not desire in the event of a life-threatening or terminally ill condition (see USHOPP: Patient Rights: Advance Directives, Personal Choice, Living Will).

1.1 All charts for patients who have executed an Advance Directive stating that they do not desire resuscitation in the event of a life-threatening condition shall be marked with a Do Not Resuscitate sticker.

1.1.1 If a patient does not have an Advance Directive, their family or

treatment team may request support and consultation from the Ethics Committee.

1.2 The attending physician and the treating staff shall be informed of such directives.

2. Withholding of Resuscitation: In the event that a patient requires resuscitation, those procedures shall not be denied except in the following condition: the patient requiring resuscitation has previously executed an advance directive stating heshe does not desire resuscitation in the event of a life-threatening condition, and that directive has not been withdrawn either in writing or verbally.

2.1 The attending physician shall write a Do Not Resuscitate order in the physician's order section of the working chart in the event that such a directive exists.

2.2 The order shall be co-signed by another physician.

3. Updating a Do Not Resuscitate Order: A Do Not Resuscitate order shall be updated every thirty (30) days by the attending physician and shall be co-signed by another physician. The rationale for continuing the Do Not Resuscitate order shall be documented by the attending physician in the medical record.

4. Standard of Care is not Lessened: A Do Not Resuscitate order does not imply a lesser standard of care for the patient. Patients with such orders shall continue to receive other supportive therapies and shall always receive the same attention to care and comfort as other patients.

5. Transfer of Patient to a Level One Care Emergency Care Provider: Life-threatening emergencies occurring at Utah State Hospital are referred to a level one emergency care provider for evaluation and treatment.

5.1 In the event that a patient is transferred to a level one emergency care provider, the receiving facility shall be provided a copy of the directive stating that the patient does not desire resuscitation.

5.2 It then becomes the responsibility of the level one emergency care provider to initiate or withhold resuscitative procedures.

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Chapter: Medical Services (MD)

Section 11: Organ Tissue Donation

Policy

Utah State Hospital (USH) patients who have not been declared legally incompetent can make their own decisions regarding organ tissue donation. If no decision or direction has been given by a patient, then the patient's family's wishes regarding organ and tissue donation will be considered.

Procedure

1. USH adheres to the Guidelines of the American Council on Transplantation. The Intermountain Organ Recovery System provides the services of a transplant coordinator who can answer questions that patients or families may have regarding organ tissue donation.
2. A patient who desires to make an anatomical gift after death may make his/her wishes known to the treatment team.
3. The patient's social worker can assist the patient in registering on-line, if desired, at 'yesutah.org'.
4. Intermountain Donor Services (IDS) is notified of all deaths (1-800-833-6667) by the unit RN. (The unit nursing director or SSRN follow up to ensure call has been made).
5. If a USH patient dies at another facility (i.e. UVRMC) the nursing staff at that facility contacts IDS.

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Chapter: Medicalⁱⁱⁱ Services (MD)

Section 12: Pain Assessment

Policy

Patients admitted to Utah State Hospital are assessed for pain at the time of admission and regularly thereafter. Information on pain management is available to patients and their families which includes up to date modalities in managing pain.

Procedure

1. Patients are assessed for pain, by medical services personnel at the time of admission and periodically thereafter.
 - 1.1 A pain assessment form is utilized, which commences with basic recognition of pain.
 - 1.2 If pain is not present, there will be a periodic screening at least every ninety days or sooner as clinically indicated.
 - 1.3 If pain is present, further evaluation of the pain, aggravating factors, duration, etc., are assessed.
 - 1.4 The pain assessment explores the relationship of pain and mental illness.
 - 1.5 A brief description of the pain management plan is included in the final section of the pain assessment.
2. Patients and their families are offered basic information regarding pain, assessment, and expression of pain and treatment options available. This information is made available through orientation information packets.
3. Patients with pain can be treated with various modalities which include, but are not limited to:
 - 3.1 Behavioral modification and relaxation techniques
 - 3.2 Medication
 - 3.3 Physical therapy
 - 3.4 Referral to a pain clinic

Chapter: ^{iv} Medical Staff

(MS)

Section 1: Medical Staff Organization

Policy

Utah State Hospital has an organized medical staff responsible for the quality of medical care subject to the ultimate authority of the Governing Body of Utah State Hospital and the Department of Social Services and Division of Substance Abuse and Mental Health of the State of Utah. The services provided are within the scope of clinical privileges delineated in the application for Clinical Privileges in Psychiatry and General Medicine.

Procedure

1. The Medical Staff of Utah State Hospital implements its responsibilities by the following organizational characteristics:
 - 1.1 Physicians are licensed to practice medicine in the State of Utah.
 - 1.2 Physicians at Utah State Hospital have facility-specific delineated clinical privileges that define the scope of patient care they may provide independently at the hospital. These privileges are reviewed by the Medical Staff Credentials Committee with referral for further review and/or recommendations by the Medical Executive Committee to Governing Body for approval.
 - 1.3 Physicians at Utah State Hospital and other licensed independent practitioners who have delineated clinical privileges are subject to the Medical Staff Bylaws and Rules and Regulations, and are subject to review as part of the hospital's performance improvement activities.
2. Utah State Hospital has a formal procedure for appointment to the Medical Staff, which is implemented by the Credentials Committee of the Medical Staff and the Medical Executive Committee, and approved by the Governing Body.
 - 2.1 The procedure for formal appointment to the Medical Staff is outlined in detail in the Bylaws of the Medical Staff. This process is explained to the applicant by sending him/her a copy of the Bylaws and Rules and Regulations of the Medical Staff during the application and interview process.
 - 2.1.1 Utah State Hospital's appointment procedure provides for, but is not limited to the following:
 - 2.1.1.1 Medical Staff membership is approved by the Governing Body in accordance with the Bylaws of the Medical Staff, and Rules and Regulations of the Medical Staff.

2.1.1.1.1 Each applicant for medical staff membership is given the opportunity to read the Bylaws and Rules and Regulations prior to his/her actual employment.

2.1.1.2 Appointment to the medical staff is contingent on specified basic qualifications including, but not limited to demonstration of current licensure; adequate experience, education and training; current professional competence; good judgement; and adequate physical and mental health status.

2.1.1.2.1 Appointment to the Medical Staff is contingent on the demonstrated ability of the hospital to provide adequate facilities and supportive services for the physician and his/her patients. As an employee of the State of Utah, each member of the medical staff will be provided with adequate indemnification for those patients entrusted to his/her care by the State of Utah.

2.1.1.2.2 Appointment to the medical staff is determined on patient-care needs for additional staff members with the applicant's skill and training. Sex, race, creed, and/or national origin are not used at Utah State Hospital in making decisions regarding the granting or denying of medical staff membership or clinical privileges.

2.1.2 Each applicant for medical staff membership completes an application that asks for information specified in the Bylaws of the Medical Staff.

2.1.3 Additional information required during the application process includes, but is not limited to the following:

2.1.3.1 previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration;

2.1.3.2 voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital; and

2.1.3.3 involvement in a professional liability action.

2.1.3.3.1 At a minimum, final judgments or settlements involving the individual are reported.

2.1.4 Utah State Hospital's Medical Staff Bylaws outline the specific process of an application for medical staff membership. The process includes, but is not limited to the following:

2.1.4.1 The applicant authorizes release of information relevant to his/her licensure, specific training, experience, current competence, and health status.

2.1.4.2 The applicant agrees to appear for an interview.

2.1.4.3 The applicant allows letters of reference to be sent to peers and/or colleagues, inquiring about suitability for appointment to the medical staff.

2.1.4.4 The applicant's appointment and all other relevant documents, including responses from references are considered in a timely manner.

2.1.4.5 The Governing Body makes the final decision of approval for medical staff membership and privileges.

2.1.5 Utah State Hospital has a corrective action process which includes, but is not limited to categories of corrective action, administrative action, automatic suspension, and summary suspension, whenever the activities or professional conduct of any person providing clinical care are considered lower than the standards and aims of the hospital or disruptive to the operation of the hospital. The procedure includes, but is not limited to:

2.1.5.1 Informal counseling by the Credentials Committee;

2.1.5.2 A letter of censure or suspension of privileges;

2.1.5.3 Administrative action;

2.1.5.4 A fair hearing process.

2.1.6 Initial appointment is for a provisional period of one year. Re-appointment is for a period of two years. A record is maintained on each staff member.

2.1.7 Utah State Hospital appoints members of the medical staff who will be in administrative positions through the same process employed for all other members of the medical staff, as there is one medical staff for all physicians.

2.1.7.1 Appointment for all members of the Medical Staff correspond to the requirements of the application process of the Division of Human Resources and the Division of Substance Abuse and Mental Health and Department of Human Services.

2.1.7.2 Individuals applying for a position on the medical staff are advised of this requirement during the interview and hiring process.

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Revised: 7-95

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Chapter: ^v Medical Staff

(MS)

Section 2: Responsibility for Quality of Professional Services

Policy

Utah State Hospital Medical Staff has the responsibility for the quality of professional services provided by all individuals with clinical privileges. All professionals employed by USH have the responsibility to improve the quality of services that they perform.

Procedure

1. The Bylaws of the Medical Staff of Utah State Hospital describe specific categories of membership which include the following categories:
 - 1.1 Active staff;
 - 1.2 Associate staff;
 - 1.3 Consulting staff;
 - 1.4 Provisional staff;
 - 1.5 House staff.
2. Officers of the Medical Staff are active members of the medical staff at the time of their nomination and election and must remain active members during their term in office. Elections are held each year
3. The clinical qualifications of all medical staff members are congruent with their responsibilities and are defined in the application for Clinical Privileges in Psychiatry and application for clinical privileges in General Medicine.
4. The Medical Executive Committee is responsible for making recommendations to the Governing Body for its approval. Such recommendations include, but are not limited to the following:
 - 4.1 The composition and structural organization of the medical staff;
 - 4.2 The procedure employed to review credentials and to delineate individual clinical privileges;
 - 4.3 Recommendations for approval for medical staff membership;
 - 4.4 Recommendations for delineated clinical privileges for each eligible

individual applying for specific clinical privileges based on training, experience, and demonstrated need for that privilege at Utah State Hospital;

4.5 The monitoring of organizational performance improvement activities of the Medical Staff, as well as the procedure to conduct, evaluate, and review important aspects of care.

4.6 The formal recommendation by which membership on the medical staff may be terminated. This is part of a corrective action process appeal as necessary and indicated and in compliance with external authorities such as law enforcement; the Division of Occupational and Professional Licensing; and the Department of Human Resources Management of the State of Utah.

4.7 The procedure for a fair hearing process.

5. The MEC receives and acts on reports and recommendations from departments and medical staff committees.

6. The medical staff holds meetings two times a month, as the Medical Executive Committee. The Medical Executive Committee is a committee of the whole medical staff and meets regularly to review findings from the ongoing monitoring and evaluation of the quality and appropriateness of care and treatment provided to patients.

6.1 The minutes of the medical staff reflect the discussion, findings, recommendations, actions, and results of actions of the medical staff.

7. At Utah State Hospital, there are no clinical departments. There is one medical staff composed of licensed physicians who function as independent practitioners and who are responsible to oversee and monitor the clinical care of patients admitted to Utah State Hospital. An independent practitioner is one who can stop or start treatment on his/her own initiative.

8. Utah State Hospital is a non-departmentalized facility with the medical staff as a whole, as authorized by the governing body, responsible for the quality of care provided in the hospital. The medical staff is represented by the President of the Medical Staff, Hospital Clinical Director, and MEC, and is accountable for all professional clinical activities within the hospital. These responsibilities include, but are not limited to the following:

8.1 Review of important aspects of psychiatric care at monthly meetings of the Medical Staff CQI Committee.

8.2 Identification, evaluation, and appropriate treatment of all medical problems occurring during the hospitalization of patients.

8.2.1 The Director of Medical Services and/or his/her designee initiates and implements the appropriate medical care necessary for each patient, including referral to members of the consulting staff when indicated or necessary. The Director of Medical Services coordinates the referral, implementation, and follow-up care of those patients requiring special medical and/or surgical treatment while hospitalized.

8.3 The Director of Medical Services, is responsible for the recruitment and supervision of nurse practitioners, and evaluation of important aspects of care provided by nurse practitioners. Ongoing supervision and consultation are provided along with definition of job description and performance management.

8.4 Upon recommendation of the Director of Medical Services and the Credentials Committee, the medical staff recommends to the MEC clinical privileges for each member of the consulting staff.

8.5 Along with the Hospital Clinical Director and Director of Medical Services and through the hospital-wide Quality Assessment and Improvement plan, which monitors important aspects of care on an ongoing basis, the medical staff assures that the quality and appropriateness of patient care provided by the medical staff is monitored and evaluated.

9. Members of the medical staff have delineated clinical privileges. These privileges are reviewed by the credentials committee with recommendations for approval by MEC to the governing body if all requirements for privileging are found to be met.

10. Utah State Hospital has a facility-wide Quality Assessment and Improvement plan which assures the same level of quality of patient care by individuals with delineated clinical privileges.

10.1 Implementation of this facility-wide plan is the responsibility of the Hospital Clinical Director and QA & I professional, acting on behalf of the Medical Staff of Utah State Hospital.

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Chapter: ^{vi} Medical Staff (MS)

Section 3: Re-Appointment to Medical Staff and Renewal of Privileges

Policy

The medical staff bylaws outline a process for re-appointment to the medical staff, as well as a re-approval of clinical privileges.

Procedure

1. The process for re-appointment to the medical staff and/or renewal of clinical privileges includes at least the following:
 - 1.1 Privileges are hospital specific;
 - 1.2 Process is approved by the governing body;
 - 1.3 Process is explained to each applicant seeking re-appointment or renewal of clinical privileges.
2. Re-appointment to the medical staff and/or the granting of delineated hospital-specific privileges is for a period of two years.
3. Re-appointment and/or renewal of clinical privileges is based on a re-appraisal of the individual at the time of re-appointment and/or renewal or revision of clinical privileges.
 - 3.1 The re-appraisal process includes but is not limited to:
 - 3.1.1 Information concerning the individual's current licensure;
 - 3.1.2 Health status with confirmation by the Director of Medical Services, if indicated;
 - 3.1.3 Professional performance, including judgment and clinical technical skills, as indicated by the results of Quality Improvement (QI) activities (including participation in monitoring patient care at medical staff meetings and other reasonable indicators of continuing professional competence).
 - 3.2 The bylaws and policies of the medical staff specify that the applicant for re-

appointment and/or renewal of clinical privileges is required to submit any reasonable evidence of current health status that may be requested by the Medical Executive Committee.

4. Peer recommendations are part of the basis for the development for continued membership on the medical staff and/or for the delineation of individual clinical privileges. The Credentials Committee and the Medical Executive Committee (MEC) review and sign the application form for privileges in psychiatry and medicine. The governing body then reviews and, if in agreement with the recommendations of the Credentials Committee and MEC, indicates their approval by signing the application form for continued clinical privileges.

5. To assure the continuing function of the medical staff, at least 90 days prior to the expiration of the current staff appointment, the medical staff coordinator mails or delivers to the member an application for reappointment.

5.1 Within 30 days of receiving the application for reappointment, the member submits to the credentials committee of the medical staff the completed application form. The re-application will also include a request for renewal or modification of privileges.

6. In addition to appraisals and re-appraisals for other purposes than appointment and re-appointment to the medical staff, a performance evaluation is done by the Hospital Clinical Director and submitted to the Department of Human Resource Management, State of Utah, annually on each member of the Medical Staff who is also a merited state employee.

7. The governing body is responsible for the final decision, based on the recommendations of the MEC, regarding an individual's re-appointment and/or renewal or revision of individual clinical privileges.

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Chapter: ^{vii} Medical Staff (MS)

Section 4: Monitoring of Important Aspects of Patient Care

Policy

As Part of the Utah State Hospital's quality Assessment and Improvement program, the medical staff attempts to assure the provision of appropriate and quality treatment through the monitoring and evaluation of the quality and appropriateness of important aspects of patient care. Specific opportunities to identify important aspects of patient care which can be improved are addressed in a timely fashion.

Procedure

1. The medical staff, through a planned and systematic process provides effective mechanisms to monitor and evaluate the quality and appropriateness of patient treatment and the clinical performance of all individuals with delineated clinical privileges. Important problems in patient care, including high volume, high risk, problem prone, multi-disciplinary, and high cost aspects of patient care are identified and resolved by a review process which leads to findings, recommendations, actions, and follow-up on an ongoing basis.

1.1 Required characteristics include, but are not limited to the monitoring and evaluation of the quality and appropriateness of patient treatment provided by all individuals with clinical privileges.

1.1.1 The Hospital Clinical Director, working in collaboration with the Director of Medical Services and the Director of Quality Resources, is responsible for assuring the implementation of a planned and systematic process which assures the quality and appropriateness of treatment provided by the members of the medical and allied professional health staff, based on their facility-specific privileges and/or job descriptions.

1.1.1.1 The medical staff is responsible for all patient care administered at Utah State Hospital.

1.1.2 Medical Staff monitoring and evaluation encompasses all major clinical activities and treatment modalities employed at Utah State Hospital.

1.1.3 Medical Staff monitoring and evaluation includes, but is not limited to the routine collection of information about important aspects of patient care provided by the medical staff and about the performance of its members. This will include, but not be limited to the following:

- a. Admission medical and psychiatric evaluation
- b. Diagnostic assessment and treatment planning.
- c. Medication prescribing patterns.
- d. Appropriate referral for consultative services when indicated.
- e. Medical management and resolution of medical problems.
- f. Responsibility for after-hour duty.
- g. Selected aspects of patient care, including but not limited to the use of seclusion and restraint, management of dangerousness and suicidal patients, and appropriate use of less restrictive treatment alternatives as available.

1.1.3.1 This information is collected through activities of the QR Director and his/her staff, and through the appropriate committees of the Medical Staff.

1.1.3.2 The Medical Executive Leadership Group and the MEC review information collected about important aspects of care in order to identify opportunities to improve patient treatment, as well as to identify and/or resolve important problems in patient treatment.

1.1.3.3 In the implementing of collection of information about important aspects of patient care, as well as in its assessment, the medical staff, with the assistance of the Director of QR and his/her staff, develops a possible objective, selective, predetermined criteria which reflects current knowledge and clinical experience, as well as current acceptable standards of care.

1.1.3.3.1 These criteria are used by the medical staff and its QI program in the monitoring and evaluation of patient care.

1.1.4 When important problems in patient care and clinical performance or opportunities to improve care are identified *via* findings from QI activities and/or committee work, recommendations are made, actions are initiated, and the effectiveness of the actions is evaluated as part of the monitoring process.

1.1.4.1 The findings from and conclusions of monitoring, evaluating, and problem-solving activities are documented as reported to the appropriate committees, including the MEC, at least monthly.

1.1.5 The results of actions taken to resolve problems and to improve patient care and information are documented in the minutes of the regular performance improvement meeting, as well as in the minutes of the meetings of the governing body, MEC, and other appropriate committee meeting minutes.

1.2 Patients requiring surgery are referred by the Director of Medical Services to appropriate members of the consulting staff for evaluation and treatment at an

appropriate facility. If admission to another facility is required, the Director of Medical Services is the liaison between USH and the other facility.

1.2.1 Requests for elective surgery are screened by the Director of Medical Services, who may consult with the hospital Executive Staff prior to authorization of elective surgery.

1.2.2 When patients require surgery, the quality of the surgical services is assessed by the following process:

1.2.2.1 There is quality evaluation through case review by the Director of Medical Services at Utah State Hospital.

1.2.2.2 The QR Director at USH maintains an ongoing communication with the QR Director at the treatment facility regarding patient care.

1.2.2.3 Since USH is a primary psychiatric facility, surgery is infrequent enough such that each patient referred to the consulting staff for surgery is reviewed for quality and appropriateness of care.

1.3 The medical staff, as represented by the Pharmacy and Therapeutics Committee, performs criteria-based, ongoing monitoring and evaluation of the prophylactic, therapeutic, and empiric use of drugs in a planned and systematic manner to help assure that they are provided appropriately, safely, and effectively.

1.3.1 The process includes, but is not limited to the following:

a. Routine collection and assessment of information in order to identify opportunities to improve the use of medications and to resolve problems in their use.

b. Selection of medications for review, addressing issues of appropriateness and effectiveness, as well as prophylactic, therapeutic, and empiric use of medications.

1.3.2 There is ongoing monitoring and evaluation of selected medications that are chosen for one or more of the following reasons:

1.3.2.1 Based on clinical experience, it is known or suspected that the medication causes adverse reactions or interacts with another drug in a manner that presents a significant health risk.

1.3.2.2 The medication is used in the treatment of patients who may be at high risk for adverse medication reactions because of age, disability, or unique metabolic characteristics. USH has defined an untoward medication reaction as one which constitutes a serious threat to the person's physical and/or psychological well-being, or causes the patient significant discomfort, such that it impedes the normal progress of the individual's treatment.

1.3.2.3 The medication has been designated through USH P&T Committee and/or Infection Control Committee for monitoring and evaluation and/or is one of the most frequently prescribed medications.

1.3.3 The process for monitoring and evaluating the use of medications

includes, but is not limited to the following:

1.3.3.1 The process is implemented by the medical staff in collaboration and cooperation with members of the allied professional health staff, including but not limited to pharmacy services, nursing services, members of the P&T Committee, and Administrative Staff members.

1.3.3.2 The process reflects current knowledge, clinical experience, relevant literature, and conformity with the Standards of Care for Use in Utah State Hospital.

1.3.3.3 The process includes the use of screening mechanisms to identify, for more intensive evaluation, problems in, or opportunities to improve, the use of a specific medication or category of medications.

1.3.3.4 Written reports of the findings, conclusions, recommendations, actions taken, and results of actions taken are maintained and reported at the monthly meetings of the P&T Committee and MEC meetings.

1.3.3.5 The results of medication usage evaluation are part of QA&I activities, as well as continuing medical education activities and are considered as part of the medical staff reappointment and delineation of privileges process.

1.4 The Medical Record Review function of the medical staff is continuous and includes at least the quarterly review of records for clinical pertinence and timely completion. Clinical pertinence includes, but is not limited to the following:

- a. Reason for admission, continued stay, and treatment.
- b. Evidence of psychiatric evaluation, medical history, and physical examination which substantiate diagnosis.
- c. Progress of patient since the last weekly/monthly note or reason(s) for lack of progress with note of any change in treatment plan.
- d. Medications employed to treat specific target symptoms of specific diagnoses.
- e. Identification of significant risk factors.
- f. Indication of status, including discharge planning as possible.

1.4.1 The Medical Records Review function assures that each medical record, or a representative sample of records, reflects the diagnosis, results of diagnostic tests, therapy rendered, condition and in-hospital progress of the patient, and condition of patient at discharge.

1.4.2 The Medical Records Review function includes a review of summary information regarding the timely completion of all medical records.

1.4.3 Members of the Medical Records Committee representing the medical staff recommend the format of the medical record, the forms used in the medical record, and the use of computer services for processing and

storage systems for medical record purposes.

1.4.4 Written reports of conclusions, recommendations, action taken, and the results of actions are maintained.

1.5 Utah State Hospital does not store and/or utilize blood and/or blood products.

1.6 The Pharmacy and Therapeutics (P&T) function is performed by the medical staff, the pharmacy, nursing, management and administration, and other services or individuals as required. The P&T monitoring function includes at least the following:

1.6.1 The development or approval of policies and procedures relating to the selection, distribution, handling, use, and administration of medications and diagnostic testing material.

1.6.2 The development and maintenance of a medication formulary or medication list.

1.6.3 The development and/or approval of protocols for unusual, investigational, or pre-investigational medications, working in collaboration with the Research Committee, which also serves as the hospital's institutional review board, Medical Staff, MEC, and Governing Body.

1.6.4 The development of written policies and procedures governing the safe administration of medications in collaboration as indicated, with the medical staff, nursing service, and if indicated, representatives of other disciplines. Policies and procedures are reviewed at least annually and revised as necessary.

1.6.5 The definition and review of all significant adverse drug reactions. An adverse drug reaction is described as "unintended, undesirable, and unexpected effects of prescribed medications or of medication errors that require discontinuing a medication or modifying the dose; require initial or prolonged hospitalization; result in disability; require treatment with a prescription medication; result in cognitive deterioration or impairment; are life threatening; result in death; or result in congenital anomalies."

1.7 Other review functions include, but are not limited to infection control, internal and external disaster plans, hospital safety, and utilization review.

1.7.1 Utah State Hospital is a psychiatric facility providing evaluation and treatment of the emotionally-ill, civilly committed, court-ordered adults or juvenile court-ordered and/or admitted children and adolescents committed through neutral and detached fact finder process residing in the State of Utah. General medical/surgical needs are assessed by the Medical Services physicians and/or nurse practitioners with referral to outside consultants and/or a local general hospital if indicated.

2. Utah State Hospital has an ongoing facility-wide QI program designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care provided by all individuals with clinical privileges to identify and to resolve problems, and to pursue opportunities to improve patient care. With the approval of the governing body, the medical staff monitors and evaluates the quality and appropriateness of patient care and clinical performance by activities including, but not

limited to:

- a. Medication usage evaluation;
- b. Medical record review;
- c. Pharmacy and therapeutics;
- d. Other indicated review functions.

2.5.1 There is a written plan for the QI program that describes the program's objectives, organization, scope, and mechanisms for overseeing the effectiveness of monitoring, evaluation and problem-solving activities. Individual and aggregate review of patients and problems is indicated in the scope of activities of the QI plan.

2.5.2 The quality and appropriateness of patient care monitoring, including the effectiveness of the QI program, is evaluated at least yearly, with revisions if indicated.

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Revised: 5-99

Chapter: ^{viii} Nursing Care Services (NC)

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- I. Ordering Medications From the Pharmacy
- J. Medication Orders Protocol
- K. Reordering Medications From the Pharmacy
- L. 30 Day Medication Review
- M. Medication Storage on the Unit
- N. Transcription of Medication Orders

- O. Mixing Medications in IV Solutions
- P. Multi-Dose Vials
- Q. Crash Carts
- R. Medication for RN Administration Only
- S. Self Medication
- T. Psychotropic Medications and Physical Illness

IV. Emergency Services

- A. Suspected Rape and Child Abuse
- B. Anaphylaxis Protocol
- C. Human Bite Protocol
- D. Treatment of Hemorrhage
- E. Emergency Burn Care
- F. Code 10 Emergencies
- G. Code Blue Emergencies
- H. Cardiopulmonary Resuscitation
- I. Use of Automated External Defibrillator (AED)
- J. Withholding Resuscitative Services
- K. Treatment of Electrical Shock
- L. Hanging Incidents Protocol
- M. Calling Paramedics Directly
- N. Poison Control: Treatment of Poison Ingestion and Overdose
- O. Seizure Protocol
- P. Use of Oronasopharyngeal Suctioning

V. Infection Control & Isolation Techniques

- A. Admission of HIV Patients
- B. Bloodborne Pathogens: Decontamination
- C. Use of Grooming and Cosmetics Supplies
- D. Handwashing
- E. Hepatitis B Vaccination
- F. HIV Infections: Confidentiality and Disclosure
- G. HIV Testing
- H. HIV Testing Protocol
- I. Infectious Waste

- J. Contaminated Waste
- K. Isolation Precautions
- L. Contaminated Linens
- M. Treatment for Pediculosis - Lice Infestation
- N. Occupational Exposure to Blood or Blood Products
- O. Sharps Management for Nursing and Medical Procedures
- P. Pets
- Q. Use of Razors for Shaving
- R. Treatment for Pediculosis - Scabies
- S. Handling Sewing Needles
- T. Control of the Spitting Patient
- U. Standard Precautions
- V. Hepatitis Panel
- W. Hepatitis Counseling
- VI. Personnel Management and Nursing Administration
 - A. Internal Bidding Procedures
 - B. Collaboration with Nursing Schools
 - C. Nursing Personnel Files
 - D. Continuing Education
 - E. Role of Nursing as a Part of Executive Staff
 - F. Family Members at Work
 - G. Fiscal Management
 - H. Grooming and Dress Standards
 - I. Licensure Requirements
 - J. New Employee Orientation
 - K. Use of Overtime Protocol
 - L. Official Communication
 - M. Patient Neglect or Abuse
 - N. Patient Acuity
 - O. Retention and Recruitment of RNs and LPNs
 - P. Vehicle Use
 - Q. RN Duties
 - R. Psychiatric Technician Job Description

- S. Psychiatric Technician Environmentalist Job Description
- T. Psychiatric Technician Mentor Job Description
- U. Licensed Practical Nurse Job Description
- V. Nursing Administrator Job Description
- W. Nurse Executive Job Description
- X. Assistant Nurse Administrator Job Description
- Y. Clinical Nurse Specialist Nursing Education Director Job Description
- Z. Clinical Nurse Specialist Job Description
- AA. Infection Control Coordinator Job Description
- BB. Staff Registered Nurse Job Description
- CC. Staffing Coordinator Job Description
- DD. Unit Nursing Director Job Description
- EE. Unit Clerk Job Description
- FF. Scheduling Protocol
- GG. Scheduling and Shift Differential
- HH. Sexual Misconduct Between Patient and Staff
- II. Staffing
- JJ. Staffing Patterns

VII. Safety

- A. Elopement
- B. Body Mechanics
- C. Employee Medications
- D. Fire Evacuation Plan
- E. Refrigerator Checklist
- F. Hot Water Temperatures
- F. Identification Badges
- G. Keys
- H. Medication Treatment Room Checklist
- I. Patient Census Verification Roll
- J. Patient, Employee, and Visitor Safety
- K. Violence Prevention
- L. Employee Theft or Financial Impropriety
- M. Tarasoff Warning

VIII. Documentation

- A. Legal Aspects of Charting
- B. Confidentiality
- C. Role of the Nurse in Discharge Planning
- D. Physician's Orders
- E. Nursing Care Plans
- F. Nursing Orders
- G. Patient Progress Notes

IX. Special Treatment Procedures

- A. Medication of Adult Patients
- B. Electroconvulsive Treatment Protocol
- C. Pre-ECT and Post-ECT Patient Care Protocol
- D. Less Restrictive Alternatives to Seclusion and Restraint
- E. Restraint and Seclusion
- F. Use of Medical Protective Devices
- G. Restrictions and Limitations of Patient Rights
- H. Levels of Suicide Precautions

X. Coordination of Care

- A. EKGs Protocol
- B. Labwork Protocol
- C. Sending Lab Requests to IHC Laboratory Protocol
- D. Clozaril Protocol
- E. Atypical Antipsychotic Medications Protocol
- F. Coumadin Protocol
- G. Depakote Protocol
- H. Dilantin Protocol
- I. Lithium Protocol
- J. Tegretol Protocol
- K. Abbreviations
- L. Audiology Clinic
- M. Dental Clinic - Admission Dental Exams
- N. Dental Clinic - Radiologic Exposures and Safety
- O. Dental Clinic - Dental Surgery Post-Operative Instructions

- P. Dental Appointments Protocol
- Q. Dietary Services - Obtaining Dietary Services
- R. Dietary Services - DrugFood Interaction Counseling for Patients
- S. Dietary Services - Guest Trays
- T. Dietary Services - Provision of Punch and Other Supplies Used for Administering Medication
- U. Dietary Services - NPO Orders
- V. Neurology and EEG Clinics
- W. Physical Therapy
- X. Podiatry and Optometry Clinics
- Y. Purchasing Dentures, Orthotics and Other Appliances
- Z. Purchasing Eyeglasses
- AA. Radiology
- BB. Patient Preps for Procedures at UVRMC
- CC. Speech and Language Assessments
- DD. Access to Warehouse Supplies
- EE. Accessing Medical Supplies and Pumps
- FF. Volunteers
- GG. Retention and Destruction of Nursing Services Documents
- HH. Facility Planning and Administration
- II. Ethical Concerns
- JJ. Utah State Hospital Statement of Patient Rights
- KK. Common Definitions
- XI. Plan for Services
 - A. Philosophy and Framework
 - B. Service Description
 - C. Scope of Services
 - D. Authority, Accountability, Responsibility, and Supervision
 - E. Goals and Objectives
 - F. Organizational Chart
 - G. Staffing
 - H. Job Descriptions and Performance Plans
 - I. Professional Behavior

- J. Staff and Scheduling
- K. Contract Staff
- L. Licensure
- M. Budget
- N. Committee Membership
- O. Education
- P. Performance Competencies
- Q. Departmental Relationships With Nursing
- R. Standards of Care
- S. Standards of Practice
- T. Standards of Performance
- U. Quality Improvement Plan

Implemented: 4-92

Revised: 12-98

Revised: 08-01

Chapter: ix Nursing Care Services (NC)

Section 2: Psychiatric Technician Acuity Pool

Policy

Psychiatric technicians are hired into an acuity pool.

Procedure

1. Applicants are referred to the Utah State Hospital Human Resources Office.
2. The acuity techs complete New Employee Orientation and Psychiatric Technician Training before being assigned to units.
3. The acuity techs are supervised by the Assistant Nursing Administrator and/or designee. Heshe is responsible for assigning techs to units and for monitoring their performance.
4. The acuity techs may bid on permanent psych tech positions as soon as they have completed the required training and as jobs become available. Acuity techs may be placed on a unit at management's discretion if there are openings that do not receive bids.
5. The six-month probationary period starts when a tech is hired by a unit as a permanent employee.

Implemented: 5-91

Reviewed: 4-92

Reviewed: 9-95

Revised: 12-98

Revised: 10-01

Chapter: ^x Nursing Care Services (NC)

Section 3: Organization of Nursing Staff on Treatment Units

Policy

The nursing staff on the treatment units of the Utah State Hospital (*i.e.*, registered nurses, licensed practical nurses, psychiatric technicians) are organized in such a manner as to allow for continuity of patient treatment under the direction of the Unit Nursing Directors (UND).

Procedure

1. All licensed practical nurses and psychiatric technicians, including mentors, clerks, and environmentalists, are responsible to the registered nurse assigned to that shift. The registered nurse assigned to the shift has full responsibility under the authority of the UND, unit administrative director, and unit clinical director.
2. All unit nursing service personnel are responsible to the unit supervising registered nurse.
3. The unit psychiatric technicians, mentors, clerks, and environmentalists are assigned job responsibilities by the unit supervising registered nurse. These assignments may be made in conjunction with the lead psychiatric technician as delegated through the unit supervising registered nurse.
4. During after hours, the SSRN is responsible for oversight of all hospital functions.

Implemented: 6-28-84

Revised: 8-22-86

Revised: 4-18-88

Reviewed: 12-90

Revised: 5-30-91

Reviewed: 9-92

Reviewed: 9-95

Revised: 12-98

Reviewed: 10-01

Chapter: ^{xi} Pastoral Services (PS)

Section 1: Pastoral Services

Policy

Patient religious preferences are identified at admission and the appropriate services are arranged or provided by the Hospital Chaplain.

Procedure

1. Pastoral services are under the direction of a chaplain who works closely with appropriate community resources.
2. Church services are provided and attendance encouraged for patients of all denominations. Church meeting schedules are posted on each unit.
 - 2.1 Patients under the age of 18 years may participate in religious services when permission is given by the parent/legal guardian.
3. Services provided by the Catholic Church may include, monthly mass, Communion service, Sacrament of Penance, consultation with a priest, Holy Communion, and other services upon request.
4. Services provided by the Church of Jesus Christ of Latter-Day Saints may include sacrament meetings, Relief Society meetings, Priesthood meetings, mutual, and other services upon request.
5. Services provided by the Protestant Churches may include interfaith or non-denominational worship services, Bible study, visits by clergy, and other services upon request.
6. The Hospital Chaplain provides services which may include interfaith services, liaison between hospital and religious community, and coordination of services with community resources, and memorial services for patients and staff.
7. Other religious services or activities are provided as needed when coordinated with the Hospital Chaplain.

Revised: 3-17-88

Reviewed: 12-90

Revised: 5-92

Reviewed: 4-93

Revised: 9-95

Revised: 11-98

Revised: 12-01

Chapter: ^{xii} Patient and Family Education (PF)

Section 1: Needs Assessment and Educational Programs

Policy

Utah State Hospital provides education and resources to patients and their families. We recognize this to be an important therapeutic tool in the treatment of our patients and will continue the development of programming and resources that will assist in this process.

Procedure

1. Educational needs of the patients and families are identified during the admission assessment process and continue throughout the treatment process and during the clinical evaluations.
2. This information is gathered by the treatment team and utilized in the Treatment Plan formulation process.
3. The Utah State Hospital offers a wide variety of educational programs and opportunities for the patients in each service area in the form of group and individual therapies. These may include, but are not limited to: medication management; information on mental illness; symptom management; drug and alcohol education; coping and relaxation skills development; social skills; leisure skills; sex education; etc.
4. The hospital offers formalized family education programs which are designed to build support systems for the patient; educate patients and family regarding mental illness; give resource material to the patients and their families; and assist them in the development of coping with mental illness.
 - 4.1 Patients and their families may attend these planned programs which are designed to meet the needs of the particular age group of the patients by signing up with the family education committee. Referrals are made by the treatment teams.
5. Documentation of attendance, progress, continued needs assessment, and evaluation is the responsibility of the group leaders and the treatment teams.
6. Formal educational services are available to assist patients toward attainment of an academic degree or vocational competency through an adult education program provided by the school district.

Reviewed: 6-98
Revised: 1-02

Chapter: ^{xiii} Pathology

Services (PA)

Section 1: Pathology Services

Policy

The Utah State Hospital provides pathology and laboratory services in accordance with the needs of the patients consistent with the nature of treatment programs through a contractual agreement with a Joint Commission accredited laboratory.

Procedure

1. Utah State Hospital provides the medical staff with laboratory testing to assist them in diagnosis and treatment of patients.
2. Ordering of Laboratory Tests.
 - 2.1 A physician's or nurse practitioner's written order is required for the performance of lab tests.
 - 2.2 The unit clerk or designee enters the ordered lab tests in the lab tracking book and the computer and prints the order.
 - 2.2.1 The order is checked for accuracy.
 - 2.3 The unit clerk/designee writes the lab order on the Daily Worksheet
 - 2.4 The unit clerk/designee notes the MDNP's order.
 - 2.5 A unit RN verifies the accuracy of the work and co-notes the order.
 - 2.6 The ordered lab tests are faxed to the laboratory.
3. A phlebotomist visits each unit to draw blood for ordered lab tests.
 - 3.1 The unit RN verifies that lab work was collected.
4. Return of lab tests are recorded in lab book.
 - 4.1 A copy of results of testing is filed in chart within 24 hours of completion of test.
 - 4.2 Lab tests are initialed by the MDNP and filed in the patient's chart.

*Implemented: 6-8-89
Revised: 11-29-90
Revised: 9-92*

Revised: 1-95
Revised: 12-98
Revised: 1-02

Chapter: ^{xiv} Patient Management (PM)

Section 1: Off-Unit Patient Activities

Policy

The Utah State Hospital provides the least restrictive environment possible in treatment of patients. The unit clinical director, with input and involvement of unit staff, determines when patients participate in on-campus and off-campus activities.

Procedure

1. The unit clinical director writes an order in the patient's chart when the patient is able to participate in on-campus or off-campus activities.
 - 1.1 As the patient's status changes, the unit clinical director writes an order reflecting the patient's current level status.
 - 1.2 If a unit has written policies and procedures regarding a level system which includes on and off unit activity privileges, the unit clinical director may write only one order corresponding to a patient's current level status. The order addressing the level system gives approval for on and off unit activities.
2. The multi-disciplinary treatment team reviews the list of all patients eligible for off-campus activities prior to the activity to approve each patient's participation.
 - 2.1 In absence of the unit clinical director, the treatment team may limit a patient's activities, but may not make them more liberal.
3. The unit RN may limit a patient's off-unit activity if it is therapeutically contraindicated.
4. News media concerns about patient off-campus activities should be directed to the Director of Public Relations.

Reviewed: 11-92
Revised: 1-93
Revised: 9-95
Revised: 12-98
Revised: 7-01

Chapter: ^{xv} Patient Management (PM)

Section 2: Post-Patient Death or Suicide Debriefing

Policy

Following the death or suicide of a patient or staff member, Utah State Hospital provides patients and staff with access to grief counseling.

Procedure

1. Staff Meeting: Unit staff and appropriate others are assembled and informed of the details of the suicide as soon as possible.
 - 1.1 Unit staff may be called in after working hours to assist in dealing with a unit that is in crisis.
2. Hospital crisis workers may be deployed to assess the situation and assist in the debriefing of the unit staff and patients, and begin bereavement groups as requested.
3. Patient-Staff Meeting: A meeting is held for patients to give them appropriate details about the suicide.
 - 3.1 As many staff members as possible attend to observe the reactions of the patients.
 - 3.2 Patients are encouraged to talk to unit staff at any time about the suicide, their thoughts, and fears of suicide.
4. Review of Privileges: A review of each patient's privileges is considered.
 - 4.1 Off-ward hospital privileges are to be temporarily limited in the event that the clinical team feels doubt concerning a patient's orientation toward suicide.
5. Memorial Service: A memorial service for the deceased patient may be held at the hospital.
 - 5.1 When the service is arranged, the family and/or hospital Chaplain may be included.

Revised: 4-5-88
Reviewed: 12-90
Reviewed: 9-92
Revised: 12-98
Reviewed: 6-01

Chapter: ^{xvi} Patient Management (PM)

Section 3: Notification of On-Call Personnel: Physician, Pharmacist, Laboratory Technologist, Administration

Policy

Utah State Hospital has 24-hour, seven-day-a-week coverage by a licensed physician to assure adequate medical and psychiatric care for the patients and to assure that appropriate admission procedures are followed during evenings, nights, weekends, and holidays. On-call for any day, including weekends, extends from 0800 one day until 0800 the following day. (This excludes the normal work week; Monday - Friday 0800-1600. The contract laboratory may be contacted 24 hours per day. Pharmacists are not on call, but may be contacted for emergency situations. An administrator is also on call each day.

Procedure

1. In the event that a patient's attending physician is not available, his designee or supervisor is called for medical or psychiatric problems or emergency situations such as seclusion, medication, area restriction, etc.
 - 1.1 During the hours of 1600 and 0800 and on weekends and holidays, the on-call physician is available.
 - 1.2 The switchboard operator has on-call schedule for authorized on-call personnel.
2. During off hours, the registered nurse assigned to the unit calls the switchboard operator stating his/her name and the unit and requests the on-call physician, pharmacist, administrator, or lab technician be contacted.
3. The operator records information on the switchboard call record and pages the appropriate person(s).
 - 3.1 If there is no response from the person paged within twenty minutes, the operator records this, re-pages or calls the person at home, and notifies the RN

on the unit.

3.2 If the person on call has not answered in a reasonable amount of time given the situation, or the situation is an emergency, then the RN has the obligation to first check with the switchboard and then exercise hisher professional judgement in directing the operator to page the attending physician, the medical OD, or the Hospital Clinical Director.

4. The on-call person is responsible to return the call in a timely manner to the switchboard.

4.1 The call is forwarded to the RN on the unit.

5. The registered nurse provides the following information to the on-call physician:

5.1 identity of the patient;

5.2 chief complaint or reason for contact;

5.3 current psychiatric and medical diagnoses;

5.4 current psychiatric and/or medical problem;

5.5 medications and allergies;

5.6 brief history associated with current problem; and

5.7 what action is suggested for the situation.

6. USH Administration on-call is notified as deemed necessary in emergency situations, such as elopements, deaths, disasters, staffing emergencies, physical facilities problems, security issues, etc. The administrator on-call does not need to be notified of medical and psychiatric concerns handled by the O.D., unless they result in an emergency as described above. The hospital Nursing Shift Supervisor can use hisher discretion when calling the administrator on-call for other issues.

Implemented: 2-26-86

Reviewed: 4-5-88

Reviewed: 12-90

Reviewed: 9-92

Revised: 8-95

Revised: 11-98

Revised: 7-01

Chapter: ^{xvii} Patient Management (PM)

Section 4: Pass Structure

Policy

The Utah State Hospital utilizes passes as a vital part of the therapeutic process. Passes offer patient an opportunity to learn skills as they transition back into the community. Passes are used to identify patients with on-grounds and off-hospital grounds privileges who are not being escorted by staff.

Procedure

1. Each patient treatment unit will identify, as part of their unit program, criteria by which patients will be assessed and may be granted the privilege of using an on-grounds or off-grounds pass.
2. Unit guidelines are consistent with the hospital structure and will only be utilized as outlined in USHOPP.
3. Each pass represents a different level of privilege(s) allowed to the patient while using their pass.

3.1 White Pass: Patient is cleared to escort themselves to and from therapeutic activities such as industrial assignment, excel house, school, OT, PT, etc.

3.1.1 The unit staff are responsible to notify the staff of the area to which the patient is going at the time the patient leaves the unit.

3.1.2 The staff member receiving the patient notifies the unit staff when the patient has reached his/her destination. If the patient has not reached their destination in a time frame considered adequate to escort themselves, the unit is also notified that the patient did not arrive.

3.1.3 This process occurs in reverse when the patient leaves the area to return to the unit.

3.2 Red Pass: A patient may have on-grounds privileges for up to an hour. They must be with another Red, Blue, or Green pass holder.

3.3 Orange Pass: A patient may be off-unit, but must remain in the immediate vicinity of the building, i.e. ramp, lawn, etc.

3.4 Blue Pass: A patient may be on-grounds for up to an hour by themselves.

3.5 Green Pass: A patient may be off-grounds for up to twelve hours by themselves for therapeutic reasons identified in the patient's treatment plan.

4. Patients are required to wear their passes while off the unit and on hospital grounds, unless escorted by staff.
5. Each patient treatment unit will utilize sign out slips that designate which patient(s) from the unit is using their pass, the description of their clothing, the time they left the unit, their destination if indicated, and the time they are due back to the unit.
 - 5.1 An exception to this is the Life Habilitation Unit which utilizes a specialized door card system based on criteria in their unit program.
 - 5.2 The LHU uses a log system for the patients to sign in and sign out when leaving the unit.
6. Each patient unit will have a structure in place which designates a staff member to check the pass slips not less than every 30 minutes to monitor the patients using their passes. Units may have the option to check these more frequently per their unit structure.

Implemented: 1-27-86

Revised: 4-5-88

Revised: 9-14-92

Reviewed: 1-10-95

Revised: 6-13-95

Revised: 11-98

Reviewed: 6-01

Chapter: ^{xviii} Patient Management (PM)

Section 5: Disposition of Personal Patient Property

Policy

Utah State statutes require the state to dispose of personal property left in the care of the agency within seven years. The statute does not require agencies to keep the property for seven years; personal property may be disposed of after a reasonable effort is made to contact the owner. Employees do not retain, use, or sell personal property of patients either as gifts from patients or as abandoned property.

Procedure

1. Clothing: Clothing left by a patient may be disposed of after an effort to contact the patient is made.
 - 1.1 Thirty days after notification, if unclaimed, the clothing may be given to other patients or disposed of by the unit.
 - 1.1.1 Efforts of notification are documented in the patient's medical record.
2. Rings, earrings, watches, radios, TVs, wheelchairs, special equipment, etc.: Items such as these that are left by patients may be disposed of after every effort to contact the patient or the patient's family has been made. Efforts to contact the patient or family are documented in the patient's medical record.
 - 2.1 If the patient is not located within 90 days, an itemized list is prepared and submitted to the Business Office.
 - 2.1.1 The Business Office will dispose of the items in accordance with state policy.
 - 2.1.2 Patient funds accounts are transferred to the State Treasurer's Unclaimed Property Fund in accordance with state policy if the patient and/or patient's family cannot be contacted.

Implemented: 3-16-83

Revised: 12-20-85

Reviewed: 4-5-88

Revised: 9-14-92

Reviewed: 8-95

Revised: 11-98

Reviewed: 6-01

Chapter: ^{xix} Patient Management (PM)

Section 6: Psychiatric Care of Patients

Policy

The attending psychiatrist is responsible for the psychiatric care of patients on the treatment unit. Psychiatric care of patients is the ultimate responsibility of the attending psychiatrist, supervising psychiatrist assigned to the area, and the Hospital Clinical Director.

Procedure

1. The attending psychiatrist treats the psychiatric problems of patients on his/her assigned unit.
 - 1.1 On evenings, nights, weekends, and holidays, the assigned psychiatrist on duty is notified of any significant concerns about each patient's psychiatric problems by the unit registered nurses, based on their professional nursing judgement, and treats identified problems until the return of the unit psychiatrist.
 - 1.1.1 Verbal orders for seclusion or restraint given on evenings, nights, weekends, and holidays are signed by the attending physician or designee within 24 hours.
 - 1.1.2 All other verbal orders are signed within seven calendar days by the attending physician or designee.
2. The attending physician meets with the Director of Medical Services and/or Medical Services practitioner assigned to the unit, as often as necessary to facilitate coordination of care.
3. If a psychiatric order is questioned, the following steps are taken to clarify the order prior to implementation.
 - 3.1 The psychiatrist who gave the order is contacted for clarification.
 - 3.2 The supervising registered nurse/Nurse Administrator is consulted about the order.
 - 3.3 The Hospital Clinical Director is consulted about the order.

4. Orders for medications with both psychiatric and medical indications state the reason for use.

Implemented: 5-26-87

Reviewed: 4-5-88

Reviewed: 12-90

Reviewed: 9-14-92

Reviewed: 9-95

Revised: 2-99

Chapter: ^{xx} Patient Management (PM)

Section 7: Medical Care of Patients

Policy

Medical Services is responsible for the medical care of patients on the treatment units. The medical care of the patient is the ultimate responsibility of the Medical Services practitioner, the Director of Medical Services, and the Hospital Clinical Director.

Procedure

1. Unit registered nurses report to the medical services practitioner assigned to the unit significant concerns about each patient's medical health, based on the registered nurses' professional nursing judgement.
2. The medical services practitioner treats medical problems for patients on his/her assigned unit, under the supervision of the Director of Medical Services or designee.
 - 2.1 On evenings, nights, weekends, and holidays, the medical OD handles medical problems by telephone, and may visit the units to provide services.
 - 2.2 Telephone orders given on evenings, weekends, and holidays are signed within seven calendar days by the attending practitioner or designee.
3. The medical services practitioner assigned to the unit reviews the medical care of each patient as necessary with the Unit Clinical Director, to facilitate the coordination of care.
4. If a medical order is questioned, the following steps are taken to clarify the order prior to implementation.
 - 4.1 Documentation in medical services section of patient chart is reviewed.
 - 4.2 The Nurse Practitioner or physician who gave the order is contacted for clarification.
 - 4.3 The Director of Medical Services is consulted about the order if it cannot be resolved with the initial attempts at clarification.
5. Orders for medications with both psychiatric and medical indications state the reason for use.

Reviewed: 4-5-88

Reviewed: 12-90

Reviewed: 9-14-92

Revised: 11-98

Revised: 2-99

Chapter: ^{xxi} Patient Management (PM)

Section 8: Smoking Regulations

Policy

Utah State Hospital regulates smoking and tobacco use to promote health and to be in compliance with Utah Code.

Procedure

1. Smoking is prohibited in any Utah State Hospital building or within 25 feet of any building entrance or operable window in accordance with Utah Code 26-38-3.
2. Smoking is prohibited in state-owned vehicles.
3. Persons under the age of nineteen are not allowed to smoke in compliance with Utah Codes 76-10-104 and 76-10-105.
4. Smoking on and off grounds is defined per unit programming structures.
5. Cigarettes, cigars and tobacco are not used to reward positive behavior; nor are they withheld as a consequence of negative behavior.
6. Due to possible blood-borne pathogens, chewing tobacco is prohibited (29 CFR part 1910.1030).
7. The medical staff may limit or discontinue smoking for a patient if:
 - 7.1 smoking adversely affects psychiatric treatment and/or
 - 7.2 the patient has a documented medical condition that would be adversely affected by smoking.
9. Smoking cessation classes, medications, and other assistance are offered to those desiring to participate.

*Implemented: 10-23-85
Revised: 2-22-88
Revised: 11-25-88
Revised: 6-20-89
Revised: 11-26-90*

Revised: 4-92
Revised: 8-95
Revised: 11-98
Revised: 7-00

Chapter: ^{xxii} Patient Management (PM)

Section 9: Assessment

Policy

The assessment aspects of the psychiatric record are the foundation for the formulation of an individualized treatment plan. The hospital is organized into service areas with unique program emphasis, resulting in varying assessment responses.

Procedure

1. Each treatment unit is responsible for conducting an integrated assessment of each patient, including clinical consideration of the patient's needs.
 - 1.1 The assessment includes, but is not limited to physical, emotional, behavioral, social, recreational, and, when appropriate, legal, occupational, and vocational needs.
 - 1.2 Clinical consideration of each patient's needs includes a determination of the type and extent of special clinical examinations, tests, and evaluations necessary for a complete assessment.
 - 1.2.1 It is determined at admission which laboratory and/or special clinical examinations each patient needs.
2. A physical examination is completed within 24 hours for each patient.
 - 2.1 The physical exam is documented in e-chart and signed off by the examiner within two regular business days of admission.
 - 2.1.1 Until the physical exam is signed off in e-chart, a complete handwritten and signed worksheet in the hard copy chart is appropriate.
 - 2.1.2 At the time the e-chart exam is electronically signed, an automated e-mail notification is sent to the unit secretary and the secretary pulls the worksheet and discards it within one business day.
 - 2.2 Physical exams done by an APRN are cosigned by a physician within 14 days.
3. An emotional and behavioral assessment of each patient is completed and

entered in the patient's record. The assessment includes, but is not limited to:

- 3.1 a history of previous emotional, behavioral, and substance abuse problems and treatment;
- 3.2 the patient's current emotional and behavioral functioning;
- 3.3 a direct psychiatric evaluation within 24 hours of admission;
 - 3.3.1 The psychiatric evaluation is documented in e-chart and signed off by the examiner within two regular business days of admission.
 - 3.3.2 Until the psychiatric evaluation is signed off in e-chart, a complete handwritten and signed worksheet in the hard copy chart is appropriate.
 - 3.3.3 At the time the e-chart exam is electronically signed, an automated e-chart notification is sent to the unit secretary and the secretary pulls the worksheet and discards it within one business day.
- 3.4 a mental status examination appropriate to the age of the patient, and
- 3.5 when indicated, by screening criteria, psychological assessments.
- 3.6 A nursing assessment of each patient is compiled within 8 hours of admission which includes information relating to the following areas:
 - 3.6.1 physical, psychosocial and environmental aspects of the patient;
 - 3.6.2 self-care, patient education, and discharge planning factors;
 - 3.6.3 input from the referring agency and the patient's family members or significant others, when feasible.
- 4. A social assessment of each patient is completed, within 14 days for civil and forensic patients or 72 hours for ARTC (Adult Recovery Treatment Center) patients, which includes information relating to the following areas:
 - 4.1 environment and home;
 - 4.2 religion;
 - 4.3 childhood history;
 - 4.4 military service history;
 - 4.5 financial status;
 - 4.6 the social, peer-group, and environmental setting from which the patient comes;
 - 4.7 the patient's family circumstances, including the constellation of the family group, the current living situation, and social, ethnic, cultural, emotional, and health factors including drug and alcohol use; and
 - 4.8 the educational needs of the patient and family.
- 5. An activities assessment of each patient is completed within 14 days or 72 hours for ARTC patients, which includes information relating to the individual's current skills, talents, aptitudes, and interests.
- 6. A vocational assessment of the patient is completed, as deemed necessary,

which includes consideration of the following areas:

- 6.1 vocational history;
 - 6.2 educational history, including academic and vocational training; and
 - 6.3 a preliminary discussion between the individual and the staff member conducting the assessment concerning the individual's past experiences with, and attitudes toward, work, present motivations or areas of interest, and possibilities for future education, training, and employment.
7. When appropriate, a legal assessment of the patient is completed which includes the following areas:
- 7.1 a legal history; and
 - 7.2 a preliminary discussion to determine the extent to which the patient's legal situation will influence his/her progress in treatment and the urgency of the legal situation.
8. When appropriate, an occupational therapy assessment is completed which includes the following areas:
- 8.1 self-care knowledge deficits;
 - 8.2 self-care learning needs;
 - 8.3 other areas of skills of daily living.

Implemented: 9-16-83

Revised: 12-85

Revised: 3-15-88

Revised: 8-14-90

Revised: 12-90

Revised: 9-92

Revised: 8-95

Revised: 12-98

Revised: 3-02

Revised: 4-03

Revised: 3-04

Chapter: ^{xxiii} Patient Management (PM)

Section 10: Individualized Comprehensive Treatment Plan (ICTP)

Policy

An individualized comprehensive treatment plan (ICTP) is developed for every patient admitted to the Utah State Hospital.

Procedure

1. It is the responsibility of the patient's psychiatrist to supervise the clinical team in developing an ICTP for patients admitted to the hospital. The treatment plan reflects the participation, involvement, and collaboration of staff from various disciplines.
 - 1.1 The clinical staff consists of the psychiatrist, registered nurse, social worker, and other discipline members as indicated by the patient needs (i.e. Recreation Therapy, Psychology, Occupational Therapy, Physical Therapy, Vocational Rehabilitation, etc.)
2. The ICTP is based on assessments that are completed by the treatment team and the preadmission assessment information whenever available.
 - 2.1 Assessments include, but are not limited to: the pre-admission assessment, initial psychiatric assessment, nursing assessment, and the physical examination.
3. A provisional treatment plan is developed within 72 hours of admission on all patients, excluding ARTC. ARTC treatment plans are developed within 24 hours. This

is an interim plan that is established to guide the treatment of the patient until a comprehensive plan can be established.

4. A comprehensive treatment plan is established by the patient's clinical treatment team within 14 days of admission (30 days for forensic evaluation patients).

4.1 ARTC treatment plans will be reviewed and updated at 14 days.

5. The ICTP includes reason for admission, Mental Health Center input, patient and family input, discharge planning information, clinical assessments, the patient's diagnosis, patient strengths to be utilized in the treatment process, patient treatment needs, identified problems and discharge goals, baseline statements, behavioral and measurable short term objectives, and modalities which include the activity, rationale/strategy, frequency and person(s) responsible for the modality.

5.1 At least every 90 days, the medical services provider checks the Axis III diagnoses for accuracy.

5.2 Objectives are written with the understanding that the time frame to achieve the objective will be at the next scheduled ICTP review.

5.2.1 ICTP reviews are scheduled at least every 30 days.

6. The ICTP is a mechanism of multi-disciplinary communication concerning the patient's care and is a permanent part of the medical record.

Implemented: 9-9-82

Revised: 12-20-85

Revised: 3-18-88

Revised: 7-89

Reviewed: 12-90

Revised: 9-92

Reviewed: 9-95

Revised: 11-98

Revised: 7-00

Revised: 1-02

Revised: 1-03

Revised: 4-03

Chapter: ^{xxiv} Patient Management (PM)

Section 11: Treatment Plan Review

Policy

Multi-disciplinary clinical staff conferences are conducted on a regular basis to review and evaluate each patient's treatment plan and his/her progress in attaining the stated treatment goals and objectives.

Procedure

1. Multi-disciplinary clinical staff conferences are held, and updated assessments and treatment are recorded in the patient's treatment plan.
2. The individual comprehensive treatment plan is reviewed and updated as frequently as clinically indicated, and at least every thirty days.
 - 2.1 Each patient's individual comprehensive treatment plan is reviewed and updated by multi-disciplinary clinical staff conferences at least every thirty days to determine adequacy of the plan and/or changes indicated.
 - 2.1.1 Treatment objectives are generally expected to change every thirty days.
 - 2.2 Documentation of the thirty-day review is accomplished by completing the updated assessments on the ICTP.
 - 2.2.1 Modifications or changes in the patient needs or long term goals are documented on the 30 day review.
 - 2.2.2 All axes of the diagnoses are reviewed and correction updates are made as needed every thirty days. Special attention should be given to provisional diagnoses and current GAF scores.
3. Documentation compliance is monitored by:
 - 3.1 treatment unit internal review procedures, which include chart monitors;
 - 3.2 Utilization Review Coordinator/Nurse; and
 - 3.3 Medical Records Department chart review (upon discharge).

Implemented: 9-9-83

Revised: 4-2-86

Revised: 3-17-88

Reviewed: 12-90

Reviewed: 9-14-92

Reviewed: 9-95

Revised: 11-98

Revised: 7-02

Chapter: ^{xxv} Patient Management (PM)

Section 12: Progress Notes

Policy

Specific ongoing documentation in the form of progress notes are kept in the patient's medical record.

Procedure

1. Progress notes may contain documentation of the following information:
 - 1.1 assessment of patient's progress in accordance with original revised treatment plan;
 - 1.2 treatment rendered to the patient, and medications ordered;
 - 1.3 clinical observations;
 - 1.4 changes in the patient's conditions, including revision of treatment plan as appropriate;
 - 1.5 response of the patient to care;
 - 1.6 consultation report; and
 - 1.7 psychosocial intervention.
2. All progress notes are entered into e-chart.
3. All entries involving subjective interpretation of the patient's progress include a description of the actual behavior observed.
4. The patient's progress and current status in meeting the goals and objectives of his/her treatment plan are regularly recorded in the patient's medical record.
5. The efforts of staff members to help the patient achieve stated goals and objectives are regularly recorded.
6. Progress notes are recorded by the physician, nurse, social worker, and, when appropriate, others significantly involved in active treatment modalities.
 - 6.1 Their frequency is determined by the condition of the patient and are recorded at least weekly for the first two months of stay and at least once a month thereafter. Psychiatric technicians record daily progress on Activities of Daily

Living sheets in the chart.

6.1.1 The notes contain recommendations for revisions in the treatment plan as indicated as well as precise assessment of the patient's progress in accordance with the original or revised treatment plan.

6.1.2 The hospital uses a "BIRP" format (BehaviorInterventionResponsePlan) or "AIRP" (A=assessment) in charting for non-physician disciplines writing progress notes.

6.1.3 Medical staff includes "Psychosocial Intervention", response to medication treatment, pertinent mental status findings, and rationale for changes of medication.

Implemented: 9-19-83

Reviewed: 12-20-85

Reviewed: 3-18-88

Revised: 9-14-92

Revised: 8-95

Revised: 7-99

Revised: 10-01

Chapter: xxvi Patient Management (PM)

Section 13: Therapeutic Leave Status

Policy

Therapeutic leave status is used only on a limited basis and is approved by the attending psychiatrist on a patient-by-patient basis.

Procedure

1. The attending psychiatrist approves all patients eligible for therapeutic leave status.
2. Persons committed to the Department under any criminal commitment are not eligible for therapeutic leave status unless court ordered.
3. Patients on therapeutic leave maintain at least weekly contact with the treatment team, and a monthly progress note is written by the social worker, registered nurse, and physician.

Implemented: 11-92

Revised: 1-93

Revised: 8-95

Revised: 12-98

Reviewed: 10-01

Chapter: xxvii Patient Management (PM)

Section 14: Return of a Patient Following Medical Separation

Policy

Upon a patient's return to Utah State Hospital after a medical separation, the attending physician writes orders as necessary, and the RN makes an entry addressing pertinent medical issues assessment and any follow-up nursing care needed.

Procedure

1. Immediately upon a patient's return, the attending physician writes orders as necessary concerning any changes in:
 - 1.1 medications;
 - 1.2 treatments;
 - 1.3 restorative and rehabilitative services;
 - 1.4 activities;
 - 1.5 therapies;
 - 1.6 social services;
 - 1.7 diet;
 - 1.8 special procedures recommended for the health and safety of the patient.
2. The rationale for the above, plus a description of the patient's condition, is contained in a physician's progress note.
3. Any modifications needed in the treatment plan are made by the treatment team.

*Implemented: 3-16-83
Revised: 2-26-86
Revised: 3-18-88
Reviewed: 12-90
Reviewed: 9-14-92
Revised: 8-95*

Revised: 11-98
Reviewed: 10-01

Chapter: xxviii Patient Management (PM)

Section 15: Rapid Re-Admissions

Policy

A patient is considered a rapid re-admission if re-admitted to the hospital within thirty days of discharge.

Procedure

1. Admission documentation required by unit on rapid re-admission:
 - 1.1 new Initial Psychiatric;
 - 1.2 new Nursing Assessment;
 - 1.3 new Social History;
 - 1.4 new Physical Assessment (unless completed within past seven days).
2. A Rapid Re-Admission form is sent to the Administrative Director from the Utilization Review office.
 - 2.1 The Rapid Re-Admission form is to be completed and returned to the Utilization Review office within seven days.

*Implemented: 6-16-87
Reviewed: 12-90
Reviewed: 9-14-92
Revised: 6-94
Reviewed: 8-95
Reviewed: 5-98
Revised: 12-98
Revised: 1-02
Revised: 5-03*

Chapter: xxix Patient Management (PM)

Section 16: Videotaping and Recording of Patients

Policy

The Utah State Hospital recognizes the therapeutic potential of videotaping patients involved in various hospital activities. In order to guarantee confidentiality, videotaping, recording, photos, *etc.*, must be done under the guidelines of the following procedures. This policy also applies for audiotapes, still pictures, movies, or any similar form of recording.

Procedure

1. No person may make any photographic record of hospital buildings, grounds, units, or patients without prior approval from the Hospital Public Information Office and Clinical Director or designee.
2. Employees making videotapes for therapeutic purposes must make every effort to assure confidentiality to the patient(s) involved.
 - 2.1 No patient may be recorded without their knowledge and consent.
 - 2.2 Videotaping is defined as a treatment procedure, with appropriate consideration given to the indications and contra-indications of the procedure.
 - 2.3 After the recording is made, it becomes the property of the hospital and may not be viewed by any individual not currently involved in the treatment of the patient. The tape may not leave the hospital grounds.
 - 2.4 No copies of the tape may be made without the written authorization of the Hospital Clinical Director and Superintendent/CEO.
3. Exceptions to the viewer regulations may be given only by the Medical Records Department.
 - 3.1 Exceptions may include clinical/educational presentations to appropriate groups.
 - 3.2 Exceptions are granted only after the patient has given informed consent on the Hospital Informed Consent for Videotaping form (USH-115-0886).
 - 3.2.1 A clinical judgment must be made by a hospital psychiatrist

verifying the patient's competence to give such an informed consent.

3.2.2 A separate informed consent form must be used for each presentation and will apply for that event only.

3.3 Requests for viewings by individuals not employed by the Utah State Hospital require the Hospital Clinical Director's signed approval.

Implemented: 5-23-89

Reviewed: 12-90

Revised: 9-14-92

Reviewed: 9-95

Reviewed: 6-98

Reviewed: 2-04

Chapter: xxx Patient Management (PM)

Section 17: Discharge Summary and Aftercare Plan

Policy

A discharge summary dictated and signed by the patient's psychiatrist is entered in the patient's record before the patient is discharged from the hospital.

Procedure

1. The discharge summary includes the results of the initial physical and psychiatric assessment and diagnosis.
2. The discharge summary includes a clinical resume that summarizes the following:
 - 2.1 the significant physical and psychiatric findings;
 - 2.2 the course and progress of the patient in the hospital with regard to each identified clinical problem;
 - 2.3 the clinical course of the patient's treatment;
 - 2.4 the final assessment, including the general observations and understanding of the patient's condition initially, during treatment, and at discharge; and
 - 2.5 the recommendations and arrangements for further treatment, including prescribed medications and aftercare.
3. The discharge summary includes the final primary and secondary diagnoses.
4. A written aftercare plan that provides reasonable assurance of continued care is developed with the participation of the appropriate mental health center staff; other professionals in the community who may be involved; the patient; and when indicated, the family or guardian.
5. Discharge summaries and other records are made available to the receiving center or agency before the actual discharge whenever possible.

*Implemented: 9-15-83
Reviewed: 12-20-85
Revised: 3-18-88*

Reviewed: 12-90
Reviewed: 9-14-92
Revised: 8-95

Chapter: xxxix Patient Management (PM)

Section 18: Caffeine Consumption

Policy

Caffeine consumption by patients may interfere with their psychiatric treatment, particularly as it reduces the effectiveness of medications.

Procedure

1. Caffeinated coffee is not available to patients in hospital food services areas.
2. Individual patients' caffeine consumption from other sources may be limited.

Implemented: 9-21-89

Reviewed: 12-90

Revised: 9-14-92

Revised: 9-95

Reviewed: 6-98

Revised: 7-02

Chapter: xxxii Patient Management (PM)

Section 19: Immunizations

Policy

All patients admitted to the Utah State Hospital will have immunizations current and specific to their age.

Procedure

1. Upon admission, the nurse practitioner includes dates of age-specific immunizations in the history and physical.
 - 1.1 Children and adolescents must produce documentation of immunizations.
 - 1.1.1 If no documentation of immunizations is available through parent/guardian, the parent/guardian must sign an immunization authorization form.
2. When no documentation of immunizations of children/adolescents is available, admission lab work includes a rubella titer.
 - 2.1 If the rubella titer is less than 1:10 (non-immune titer), the immunization series is given as suggested by the Utah State Health Department's Vaccine Schedule for Children Older than 7 Years Old.
 - 2.1.1 MMR, Td, CPV gtt's.
 - 2.1.2 Two months after 2.1.1 - Td, CPV gtt's.
 - 2.1.3 Six to twelve months after 2.1.2 - Td, CPV gtt's.
 - 2.2 If the rubella titer is greater than 1:10 (adult immune titer) and the child/adolescent has not had a recent MMR, the patient receives the second dose MMR as suggested by the American Academy of Pediatrics.
 - 2.2.1 Second dose MMR when patient is middle school/junior high school age.
3. All female patients of child bearing age who require immunizations must have a negative serum HCG before the immunizations are administered.
4. All patients admitted to the Utah State Hospital receive Td immunization if there is not a documented Td immunization in the past ten years.

Reviewed: 2-02

**Chapter: xxxiii Patient
Management (PM)**

**Section 20: Financial Transactions
and Gift Exchanges Between Patients
and Employees**

Policy

Utah State Hospital prohibits financial transactions between patients and employees and exchanging or giving of gifts.

Implemented: 4-27-87

Revised: 4-5-88

Reviewed: 12-90

Revised: 9-14-92

Reviewed: 8-95

Reviewed: 9-97

Reviewed: 12-01

Chapter: xxxiv Patient Management (PM)

Section 21: GMI Review and Recommendations for Transfer Policy

Guilty and Mentally Ill (GMI) offenders committed to the Utah State Hospital are reviewed every six months in accordance with UCA 77-16a-203.

Definitions

1. Board: Board of Pardons.
2. GMI Offender: Any person committed to the Department of Human Services under UCA 77-16a-103.
3. Hospital: The Utah State Hospital.
4. Review Team: A team designated by the Hospital Clinical Director to review GMI Offenders.
5. UDC: The Utah Department of Corrections.

Procedure

1. The Hospital Clinical Director designates a review team to evaluate the mental status of every GMI Offender receiving treatment at Utah State Hospital.
 - 1.1 The review team consists of three people: at least one psychiatrist and two other staff members with degrees in psychology, social work, or nursing.
 - 1.1.1 If the offender is mentally retarded, the review team includes or will invite an individual who has professional experience in mental retardation treatment.
 - 1.2 Reviews are conducted at least every six months.
2. The review team evaluates the mental condition of the offender and makes a report to the Board, UDC, and/or court of jurisdiction which includes the following:
 - 2.1 current mental condition;
 - 2.2 progress since commitment;
 - 2.3 prognosis;
 - 2.4 recommendation whether the offender should be transferred to UDC, referred back to court for further disposition, or remain in the custody of the

Department of Human Services.

3. The hospital provides to the UDC Medical Administrator a copy of the reviewing team's recommendation and:

- 3.1 all available clinical facts;
- 3.2 diagnosis;
- 3.3 course of treatment received;
- 3.4 prognosis for remission of symptoms;
- 3.5 potential for recidivism;
- 3.6 estimation of the offender's dangerousness, either to self or others; and
- 3.7 recommendations for future treatment.

4. If the Hospital and UDC do not agree on the transfer of a GMI offender to UDC, the issue is forwarded to the mental health advisor for the Board.

4.1 The hospital provides copies of all reports and recommendations to the mental health advisor for the Board.

5. The Board's mental health advisor makes a recommendation to the Board on the transfer and the Board issues a decision.

6. UDC notifies the Board whenever a mentally ill offender is transferred from the hospital to UDC.

Implemented: 7-92

Reviewed: 9-95

Revised: 11-98

Reviewed: 3-02

Chapter: xxxv Patient Management (PM)

Section 22: GMI Recommendation for Parole

Policy

When a GMI offender who has been committed to the hospital becomes eligible to be considered for parole, the Board of Pardons shall request a recommendation from the Hospital Clinical Director and from UDC before placing an offender on parole.

Definitions

1. Board: Board of Pardons.
2. GMI Offender: Any person committed to the Department of Human Services under UCA 77-16a-103.
3. Hospital: The Utah State Hospital.
4. UDC: The Utah Department of Corrections.

Procedure

1. In the event that a GMI offender becomes eligible to be considered for parole, the Board shall request a recommendation from the Hospital Clinical Director.
 - 1.1 The recommendation shall include:
 - 1.1.1 all available clinical facts;
 - 1.1.2 the diagnosis;
 - 1.1.3 the course of treatment received;
 - 1.1.4 the prognosis for remission of symptoms;
 - 1.1.5 the potential for recidivism;
 - 1.1.6 the estimation of the offender's dangerousness to self or others;
and
 - 1.1.7 a recommendation for future treatment.
2. The Board mental health advisor prepares a report for the Board.
3. Based on the report the Board may place the offender on parole.
 - 3.1 The Board may require treatment as a condition of parole.

3.2 Failure to comply with treatment is basis for parole violation.

4. UDC may provide treatment by contracting with the Department of Human Services, a local mental health authority, any other public or private provider, or in-house staff.

5. UDC, through Adult Probation and Parole, monitors the status of mentally ill offenders placed on parole.

Implemented: 7-92

Reviewed: 9-95

Reviewed: 5-98

Reviewed: 3-02

Chapter: xxxvi Patient Management (PM)

Section 23: NGI Continuing Review, Conditional Release, and Discharge

Policy

In accordance with UCA 77-162-304, Utah State Hospital reviews the status of each NGI defendant receiving treatment at least once every six months.

Definitions

1. Board: The Board of Pardons.
2. Hospital: Utah State Hospital.
3. NGI Defendant: Any person committed to the Department of Human Services as Not Guilty by Reason of Insanity under UCA 77-14-5.
4. UDC: The Utah Department of Corrections.

Procedure

1. The Hospital Clinical Director designates a review team to evaluate the mental condition of every NGI defendant receiving treatment at Utah State Hospital.
 - 1.1 If the defendant is mentally retarded, the review team shall consult an individual who is a mental retardation professional.
 - 1.2 Reviews are conducted every six months.
 - 1.3 NGI defendants are reviewed to determine if they are eligible for conditional release, discharge, or if they require further treatment at USH.
2. All committee findings and pertinent data are submitted to the court of jurisdiction, prosecuting attorney, and defense attorney.
 - 2.1 The hospital notifies the court of jurisdiction when a defendant becomes eligible for discharge if the review team finds:
 - 2.1.1 the defendant has recovered from his mental illness; or
 - 2.1.2 the defendant is still mentally ill but does not present a substantial danger to self or others.
 - 2.2 The hospital notifies the court of jurisdiction when a defendant becomes eligible for conditional release if the review team finds:
 - 2.2.1 that the defendant is not eligible for discharge, but that his mental

illness and dangerousness can be controlled with proper care, medication, supervision, and treatment if conditionally released.

2.2.2 The hospital prepares a conditional release plan that lists the type of care and treatment that the defendant needs and may recommend a treatment provider.

2.2.2.1 The conditional release plan and the review team's report is provided to the court, the prosecuting attorney, and the defendant's attorney.

*Revised: 4-99
(policies combined)*

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Management (PM)

Section 24: Visitors

Policy

Utah State Hospital encourages and supports family, friends, volunteers, and appropriate others visiting patients.

Definitions

Weekday: Monday through Friday.

Weekend: Saturday and Sunday.

Off-Grounds Visit: An approved visit which occurs off Utah State Hospital grounds.

On-Grounds Visit: An approved visit which occurs on Utah State Hospital grounds.

On-Ward Visit: An approved visit which occurs on the treatment unit.

Supervised Visit: Visit that requires staff supervision.

Unsupervised Visit: Visit that does not require staff supervision.

Procedure

1. Unit weekday visiting hours:
 - 7:00 pm to 9:00 pm - Forensic Unit.
 - 4:00 pm to 9:00 pm - Children's Unit, Adolescent Unit.
 - 9:00 am to 9:00 pm - All other treatment units.
2. Unit weekend visiting hours:
 - 9:00 am to 9:00 pm - All treatment units.
3. Family, friends, clergy, legal counsel, volunteers, and appropriate others may visit patients.
 - 3.1 Persons desiring to visit minors must obtain approval by the parent/legal guardian and the unit clinical staff.
 - 3.2 Visits by ex-patients are approved on a case-by-case basis by the patient's physician or physician on call, and upon the physician's written order.
4. Clearance. Utah State Hospital encourages visitors to phone and obtain clearance before visiting.

4.1 Attorneys and clergy visiting patients in an official capacity may visit at times other than the above identified visiting hours.

4.1.1 Attorneys and clergy are encouraged to contact the patient's treatment team prior to visiting.

4.1.2 Attorneys and clergy visiting in an official capacity are encouraged to obtain a "visitor slip."

4.2 Visits that disrupt a patient's therapy program or meals are discouraged.

4.3 Special visits in emergency situations are accommodated. Those requesting special visits obtain clearance by the patient's physician on call physician.

5. Visitor Slip. Upon arrival at Utah State Hospital, visitors obtain a "visitor slip" from the switchboard, which is located at the main entrance of the Hening Administration Building.

5.1 The switchboard informs the unit of a visitor's arrival and, upon approval, provides a "visitor slip" to the visitor.

5.2 The visitor presents the "visitor slip" and proper identification upon arrival to the unit.

6. Visitors may obtain a visitor's pass with approval from the patient's physician. Visitors with passes may go directly to the patient's unit and do not need to check in at the switchboard. The physician writes an order in the patient's chart.

7. Visits may be limited or terminated if deemed non-therapeutic by the unit clinical director or physician on call. Justification for limitation or termination is documented in the patient's medical record. Doctor's orders limiting visits must be reviewed every seven days and a new order written if limitation is to continue.

8. Patients may refuse visits.

8.1 When a patient refuses a visit, visitors will be notified.

8.2 Such an event is documented in the patient's medical record.

9. Each unit provides a designated visiting area for visitors and patients.

9.1 Visitors remain in the visiting areas and do not access patient living areas.

10. Restricted Gifts/Items. Visitors desiring to bring gifts/items are encouraged to obtain clearance from the patient's treatment team prior to bringing the gift/item on the unit.

10.1 Weapons or items determined to be "sharps" are not allowed on the hospital grounds.

10.2 Purses are discouraged on the units and visitors encouraged to lock them in their private vehicles.

10.3 Food items require staff clearance prior to visit.

10.4 Money being given to patients is brought to the switchboard. The switchboard operator gives a receipt to the visitor.

10.4.1 Exceptions may be made on unit level for small amount of money

received.

10.5 Glass containers are not allowed on the treatment units.

Implemented: 9-92

Revised: 1-93

Revised: 8-95

Revised: 6-98

Revised: 8-99

Chapter: xxxviii Patient Management (PM)

Section 25: Home Visits

Policy

Home visit opportunities are provided to patients with input and approval of treatment staff.

Definitions

1. Home Visit - An activity which is therapeutically indicated, is approved by the treating physician and communicated to the responsible mental health center, and which allows the patient to leave the hospital grounds under the supervision of approved family or friends for purposes stated in the patient's home visit form. Home visits may be requested by the patient, the patient's family, friends of the patient, or hospital staff. A home visit is an overnight stay.

Procedure

1. Home visits are requested by the patient, guardian, family, and/or significant others.
2. All requests for a home visit are reviewed by the clinical treatment staff for appropriateness.
 - 2.1 Staff review and make sure the home visit form includes the proposed therapeutic goals.
3. Home visits are granted when:
 - 3.1 the visit has a therapeutic intent consistent with the goals of the ICTP (*i.e.*, integration into the community, developing relationships with family, etc.);
 - 3.2 the responsible mental health center is notified of home visits as part of the treatment plan at the time of initiation of visits. A crisis safety plan is requested from the mental health center for pediatric visits.
 - 3.2.1 The community mental health center approval is documented in the patient's medical record.
 - 3.3 the visit is incorporated into the patient's treatment plan
 - 3.4 the family is notified when applicable
 - 3.5 tarasoff, if indicated, is notified
 - 3.6 the treating physician writes an order for the home visit.

4. Persons providing patients a home visit receive a Home Visit Data Sheet which includes, but is not limited to:
 - 4.1 medications (dosage and time);
 - 4.2 activities that are not appropriate for the patient;
 - 4.3 the goals of the visit
 - 4.3 who to call in the event of an elopement, acting out behavior, accident; etc.
 - 4.4 expected time of departure from and return to the hospital.
5. A Home Visit Form is completed for each home visit.
 - 5.1 The social worker initiates and includes objectives on the home visit data sheet.
 - 5.1.1 Nursing staff completes medication information and reviews form with responsibility party.
 - 5.2 After the patient returns, the nursing staff completes the form, reporting on the home visit and whether the patient met the goals.
6. Forensic patients are not allowed home visits unless approved by a court order or permission granted by the Board of Pardons.

Reviewed: 1-93
Revised: 8-95
Revised: 6-98
Reviewed: 10-01
Revised: 3-04

Chapter: Patient Management (PM)^{xxxix}

Section 26: Patient Death Immediate Actions

Policy

The Utah State Hospital implements the following procedures when a patient death occurs. The medical staff secures autopsies for all patient deaths in which an autopsy is indicated.

Procedure

1. When a patient is without respiration, pulse, and blood pressure, for a significant period of time, the unit RN, in collaboration with the shift supervisor and medical OD, pronounces the patient dead.
 - 1.1 Hospital Security, Unit Staff and/or Shift Supervisor are called to secure the scene, if death occurs on campus.
 - 1.1.1 Nursing staff removes all patients from the area.
 - 1.1.2 Hospital Security restricts all non-essential others from the area.
2. In accordance with UCA 26-4-7, Hospital Security immediately notifies the Provo Police of the death (379-6210).
3. The nursing staff care for the body while not interfering with a potential investigation.
 - 3.1 Clothing, IV's, restraints, or any other items associated with the decedent are not removed or tampered with until the responding assigned law enforcement investigator has first conducted an inspection of the body and location of the death scene and thereafter relinquished the full care and custody of the body to the nursing staff.
4. Whether the death occurred on or off USH campus, the unit RN notifies the following (after hours the SSRN is accountable to ensure calls are made by unit RN):
 - 4.1 Switchboard operator.
 - 4.2 The administrator on call.
 - 4.2.1 The administrator on call notifies the Hospital Superintendent and Risk Management.
 - 4.2.2 The Hospital Superintendent notifies the Division of Substance

Abuse and Mental Health, the Department of Human Services, and the Attorney General's Office.

- 4.3 The Hospital Clinical Director.
- 4.4 The psychiatrist on call.
- 4.5 The patient's significant other, if available.
 - 4.5.1 The patient's social worker may be asked to notify the family/significant others.
- 4.6 The Hospital Patient Advocate should be notified via e-mail.
- 4.7 Intermountain Recovery (1-800-833-6667).
5. When contacted by a law enforcement duty investigator, the physician or nurse gives the decedent's name, date of birth, race, next-of-kin, and known circumstances surrounding the death.
 - 5.1 The investigator may conduct an inspection of the decedent and location of the death scene.
 - 5.2 The investigator may request a copy of the decedent's medical chart.
6. The Hospital Medical ODdesignee contacts the state Medical Examiner's Office to discuss the circumstances surrounding the death (375-3601 or 584-8410).
 - 6.1 If the Medical Examiner states that an autopsy is indicated, USH provides medical information as appropriate and requests a copy of the autopsy findings.
 - 6.1.1 The Medical Records Manager is responsible to coordinate the release of medical information and the written request for a copy of the autopsy findings.
 - 6.2 If the Medical Examiner does not require an autopsy and USH criteria for an autopsy are met, the Clinical Director/designee informs the Legal Services Manager who makes a formal request for an autopsy to the Attorney General for the Medical Examiner's Office.
7. The Hospital Medical ODdesignee requests an autopsy if one of the following criteria are met:
 - 7.1 Unexpected or sudden death while in apparently good health.
 - 7.2 Deaths in which the cause of death is unknown with certainty on clinical grounds and in which an autopsy could provide valuable medical information.
 - 7.3 To protect the hospital in a potential liability situation.
 - 7.4 The patient's family requests an autopsy.
8. The law enforcement investigator will inform the unit nurse of arrangements for removal of the body either to a morgue, funeral home, or to the Medical Examiner's Office.
 - 8.1 Disposition of the body must be approved by the office of the Medical Examiner and the Hospital Medical ODdesignee.
9. In the event that a patient expires while on separation from USH, the Hospital

Medical ODdesignee will contact the physician attending the patient at the time of the patient's death to request that the above procedures are followed.

10. The Hospital Medical ODdesignee is responsible to notify the Medical Staff and, specifically, the attending physician when an autopsy is performed.

Initiated: 6-96
Revised: 11-98
Revised: 1-02

Chapter: Patient Management (PM)^{x1}

Section 27: Industrial Security

Policy

Appropriate supervision is provided to prevent elopement of patients from industrial assignments.

Procedure

1. Employees signing out patients for industrial assignments are responsible to call each industrial area as patients leave for an industrial work site to inform the industrial area coordinators that the patient(s) have left the unit.
 - 1.1 If the patient is being escorted by staff, a call is not necessary.
 - 1.2 Units call to inform industrial areas when patients will not be at work or when they will be late.
 - 1.3 If the industrial area cannot be reached by phone, it is the unit's responsibility to escort the patient(s) to the industrial area coordinator.
2. Industrial areas inform the unit that a patient has reached his/her industrial assignment area.
 - 2.1 If a patient has not reached the assigned industrial site within five minutes of receiving notification that the patient has left the unit, the industrial area coordinator calls the unit.
3. Industrial areas will call the unit to inform the unit that the patient(s) have completed work assignments and are returning to the unit.
 - 3.1 All calls are documented.
 - 3.2 If the unit cannot be reached by telephone, it is the responsibility of the industrial area coordinator to escort the patient(s) back to the unit.
4. Units let the industrial area know when patients have returned to the unit.
 - 4.1 If the patient(s) have not returned to the unit within five minutes of being informed that they have left the work site, the unit calls the industrial area to follow-up.

Implemented: 6-15-88

Reviewed: 8-92

Reviewed: 9-95

Revised: 10-01

Chapter: Patient Management

Section 28: Use of Handcuffs on Patients

Policy

Handcuffs are not generally used on USH patients. They may only be used when necessary under carefully defined circumstances.

Procedure

1. Handcuffs are carried and used only by security staff.
2. Use of handcuffs by hospital security on USH patients may only be done when a patient -
 - 2.1 who is off the treatment unit threatens or implies intended violence and attempts to carry it out, or
 - 2.2 is being returned to the hospital after elopement, or
 - 2.3 has a history of violence or escape and needs to be escorted by security to off-unit services.
 - 2.2.1 In this case a doctor's order for use of handcuffs is also required.
3. When security staff is transporting a patient in a vehicle, use of a vehicle with a cage as a replacement for handcuffs is considered.

Implemented: 12-99

Chapter: Patient Management (PM)^{xli}

Section 29: Elopement Procedure

Policy

Utah State Hospital responds to elopements to ensure patient and community safety. In the event of patient elopement, hospital personnel follow a facility-wide procedure.

Procedure

1. In the event of an elopement, the person directly responsible for the patient's supervision immediately notifies the security department by radio and the switchboard operator by phone (44222).
 - 1.1 When reporting an elopement, a brief description of the patient is given, including name, age, hair color, clothes (if known), and last place seen.
 - 1.2 The staff responsible for the patient notify the unit charge RN.
2. Hospital security immediately coordinates with the unit personnel (or SSRN if after hours) a search of the hospital grounds.
 - 2.1 Unit staff acquainted with the patient and circumstances assist if and when appropriate with the on-grounds search.
3. If patient is suspected to have left grounds or is not located within 10 minutes, hospital security notifies local police.
 - 3.1 Security also notifies other police agencies of the elopement when pertinent to the situation, such as police from patient's CMHC catchment area.
4. The unit charge RN is responsible to ensure that all aspects of the elopement protocol are implemented.
 - 4.1 If during 8 am - 5 pm Monday-Friday, business hours, the RN notifies:
 - 4.1.1 Unit SMT members
 - 4.1.2 USH administration (USH administration ensures that the Superintendent is notified.)
 - 4.2 The unit SMT is responsible, during business hours, to notify:
 - 4.2.1 CMHC
 - 4.2.2 Patient's family members
 - 4.2.3 Tarasoff person(s) if applicable

- 4.3 If after hours, the unit RN notifies:
 - 4.3.1 SSRN
 - 4.3.2 Unit AD
 - 4.3.3 USH Psychiatrist OD
 - 4.3.4 CMHC
 - 4.3.5 Patient's family
 - 4.3.6 Tarasoff person(s) if applicable
- 4.4 If after hours, the SSRN notifies:
 - 4.4.1 AOD
 - 4.4.2 Superintendent
- 5. The unit RN is responsible to document the elopement incident in the patient's record as well as the Patient Incident Reporting System (PIRS).
 - 5.1 Unit personnel are responsible to document contacts and/or attempts to contact Tarasoff person(s), family members, and CMHC as outlined in this policy when they have responsibility to notify. The charge RN documents this if the elopement occurs after hours.
 - 5.2 The AD is responsible to complete the administrative follow-up section of the PIRS as the elopement report to administration. The UND completes this if the AD is not available.
- 6. Any updated information regarding the patient who has eloped (such as information regarding whereabouts, safety concerns, return of patient, or other information) is communicated to USH administration by the unit SMT or charge nurse depending on the time the information is received. The charge RN keeps the SSRN updated each shift as to the status of the patient.
 - 6.1 When patient is located, the RN follows notification protocols as outlined in #4 above.
- 7. The Incident Review Committee determines if the elopement qualifies as a sentinel event. If so, the unit SMT conducts a root cause analysis of the situation, which may include meeting with the patient community and other unit employees to assess the situation and make recommendations.

Revised: 9-92
Reviewed: 9-95
Revised: 7-99
Revised: 10-00

Chapter: ^{xlii} Patient Management (PM)

Section 30: Cellular Phones and Radios

Policy

The hospital utilizes cellular phones, talk-about radios, and 2-way radios to facilitate communication among staff members caring for patients and to ensure safety for staff and patients, obtain quick response to crisis and for other essential needs.

Procedure

1. Cellular Phones. Cellular phones are used by staff when taking patients off USH campus.
 - 1.1 Employees are given a cellular phone when checking out a state vehicle at the switchboard.
 - 1.1.1 Phones must be with employee and turned on at all times.
 - 1.1.2 Phones are used for hospital business and emergency purposes only.
 - 1.1.3 Phones are charged by the switchboard operator as needed.
 - 1.1.4 Switchboard maintains a list of each vehicle and the phone number assigned to the vehicle.
 - 1.2 Additional cellular phones are available in the Nursing Administration Office.
 - 1.2.1 A check sheet is completed and signed by the employee responsible for the phone when taking and returning the phone.
 - 1.2.2 Cellular phones are to be charged by the SSRN weekly.
 - 1.3 Cellular phones are used by the psychiatric and medical physicians on call and may be checked out from the switchboard.
2. Talk-about radios are used by staff when taking patients on group activities to facilitate communication between staff members who may need to be in different locations on the activity. Talk-about radios are used on recreational activities and other hospital outings: on-grounds, in the community, and on camp trips.

- 2.1 Each unit has 2 radios. In addition, the Therapeutic Recreation (TR) discipline has 4 radios.
- 2.2 Unit radios are checked out from the nursing station on a sign-out sheet.
- 2.3 If more than 2 radios are needed, additional radios may be checked out from the TR equipment room by signing a sign-out sheet.
- 2.4 All radios need to be checked back in by the person responsible for the radios on the sign-out sheet indicating that the radios are returned.
- 2.5 The hospital radios use channel 14, code 14.
- 2.6 The radios operate on a take turn basis, so other people may be talking on this channel. Caution should be used to keep hospital confidentiality. Only first names will be communicated over the radio.
- 2.7 The talk-about radios are designed for use in ranges of up to 2 miles in open flat areas. Range is decreased by buildings, trees, mountains, foliage, etc.
- 2.8 Radios are to be kept clean and dry. If the radio gets wet, the staff is to turn off the radio immediately and make sure the battery compartment is dry.
- 2.9 Radios use AA batteries which should be checked and replaced as needed by each unit.
3. Two-way radios are used by each unit to communicate with each other on-grounds for unit issues or emergencies, notify hospital security of emergencies, and communicate with the hospital while on off-grounds activities within the local community.
 - 3.1 Each unit is issued a specific number of radios based on need.
 - 3.2 Each unit is responsible for the radios assigned to that unit.
 - 3.3 Channels are assigned by the hospital to each unit.
 - 3.4 Radios are to be used when escorting groups, high profile patients, elopement risk patients, etc., on-grounds.
4. Unit administration will designate a person or persons responsible for cellular phones, talk-about radios, and two way radios.

Chapter: Patient Management (PM)^{xliii}

Section 31: Intensive Review of Clinical Incidents

Policy

Clinical incidents of substantial concern are reviewed intensively so that patient care procedures may be improved.

Definitions

Sentinel Event: An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

Root Cause Analysis: A process for identifying the basic or causal factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event.

Procedure

1. A variance from expected patient care procedures and outcomes on a treatment unit is reported by nursing unit staff and reviewed by the service management team (SMT) of that unit.
 - 1.1 All incidents of substantial concern, including all uses of seclusion and restraint, medication errors, and patient injury are reported through the Patient Incident Reporting System (PIRS)
 - 1.2 The unit staff and shift supervisor reports include significant changes in medical condition such as acute illness, same day surgery, and medical separations.
2. A unit-level administrator reviews each PIRS entry within 5 working days of the incident and takes appropriate action.
 - 2.1 Completeness of the report is assessed.
 - 2.2 Incidents reviewable by JCAHO are reported to them within 5 working days. These incidents include unanticipated death, major permanent loss of function not related to the natural course of illness, suicide, and rape.
 - 2.2.1 A unit administrator who becomes aware of a JCAHO reviewable incident brings that incident to the attention of the Quality Resource Director and a member of executive staff immediately.
 - 2.3 Incidents meeting the definition of a Sentinel Event are identified and an assignment is made to do a root cause analysis and action plan.

2.4 The root cause analysis focuses primarily on system and processes, not individual performance.

2.5 The product of a root cause analysis is an action plan which identifies strategies for implementation which reduce the risk of similar events occurring in the future.

2.5.1 The plan addresses the responsibility for implementation, oversight, time lines, and strategies for measuring the effectiveness of the actions.

2.5.2 The report identifies changes that can be implemented to reduce risk, or formulates a rationale for not undertaking such changes. These changes are made in a timely manner at the unit level under the direction of the SMT which documents the process in their minutes.

2.6 A copy of the root cause analysis report with the proposed action plan is filed with the Quality Resources (QR) office, which evaluates these reports for trends.

2.7 The quality resource director reports findings at least quarterly to the performance improvement (PI) council, which may initiate further intense analysis of processes, which lead to trends.

2.8 Quality Resources provides full documentation of the root cause analysis of reviewable incidents to Joint Commission within 45 days of the self-report or of being placed on Accreditation Watch.

2.8.1 An executive staff member adds the sentinel event to the executive staff agenda for follow up and it remains on the executive staff calendar until the root causes are identified and an action plan is completed.

2.9 Executive staff logs completion of the follow-up section of PIRS reports and contacts unit administrators for completion when follow-up reports are deficient.

3. The unit SMT reviews each PIRS event and takes appropriate action.

3.1 Particular attention is extended to:

3.1.1 Multiple instances of restraint or seclusion experienced by an individual within a 12 hour time frame;

3.1.2 The number of episodes per individual; and

3.1.3 Instances of restraint or seclusion that extend beyond 12 consecutive hours.

3.2 A unit administrator creates a weekly summary report of PIRS incidents and presents it to the SMT as an agenda item in weekly SMT meeting.

3.2.1 The report includes a statistical statement of the number of seclusion and restraints and the status of defusing and incident review for each incident.

3.2.2 Safety concerns identified in the debriefings are listed.

3.2.3 A plan to resolve safety concerns and improve clinical procedures

is written.

3.2.4 Impact of the incident(s) on treatment plan(s) is explained in the report.

3.2.5 Staff concerns needing follow-up are listed.

3.3 When approved by the SMT, a copy of the SMT minutes are forwarded to a member of the executive staff.

3.4 The executive staff reviews each unit's weekly PIRS summary report and takes action on issues of hospital-wide importance.

3.4.1 Executive staff involves Quality Resource staff to do analysis as needed and calls issues to the attention of the PI Council and UR committees when needed.

4. When the Suggestion/Concern committee receives information of value to improving the quality of care, that information is utilized.

4.1 Individual suggestions and concerns are responded to by the persons assigned by the Suggestion/Concern Committee.

4.2 The quality resources office files a copy of these forms with their responses and aggregates the data contained therein.

4.3 The manager of the Suggestion Committee reports results of the Suggestion Committee at least quarterly to the PI Council.

5. When incidents of concern come to the attention of the USH patient advocate, that information is reviewed and utilized to improve patient care.

5.1 The patient advocate meets with patients who may have concerns.

5.2 The advocate relays critical incident information to the attending psychiatrist, Hospital Clinical Director (HCD), or member of hospital Executive Staff, who assigns follow up.

5.3 Results are shared with the patient advocate and the QR director.

5.4 The QR director makes quarterly reports to the PI Council.

6. The Performance Improvement council reviews control charts on PIRS incidents monthly.

7. As knowledge is obtained from individual case study or aggregate review which has the potential to improve patient care, the information is disseminated under the direction of the HCD who arranges for implementation as appropriate.

Initiated: 06-99

Revised: 8-01

Revised: 3-04

Chapter: ^{xliv} Patient Rights

(RI)

Section 1: Utah State Hospital Statement of Patient Rights

Policy

Utah State Hospital supports and protects the fundamental human, civil, constitutional, and statutory rights of each patient.

Procedure

1. Statement of Patient Rights. The Utah State Hospital Patient Rights Statement describes the rights of patients and the means by which these rights are protected and exercised.
 - 1.1 A copy of this statement is posted in various areas of the hospital.
2. Informing Patients of Their Rights. Each patient is informed of his rights in a language the patient understands.
 - 2.1 Each patient receives a written statement of his/her rights.
3. Access to Treatment. Patients have access to treatment regardless of race, religion, sex, ethnicity, age, or disability.
 - 3.1 Each patient is entitled to considerate and respectful care.
4. Admission. Patients have the right to an explanation of admission status and the provision of the law pertaining to their admission.
5. Notice of Right to Release. Involuntarily civilly committed patients are informed of their right to release and are assisted in making requests for release.
 - 5.1 Civilly committed patients may petition the court for release within 30 days of the original commitment date and every six months thereafter.
6. Personal Dignity. Personal dignity is recognized and respected in the provision of care and treatment of each patient.
7. Personal Privacy. The personal privacy of each patient is assured and protected within the constraints of the individual comprehensive treatment plan.
 - 7.1 Staff respect a patient's right to privacy by knocking on the door of his/her room before entering.

7.1.1 In an emergency situation, or during night checks, staff may not knock on the door before entering.

8. Legal Counsel. Patient have the right to legal counsel and an attorney of their choice.

8.1 If the patient has no attorney or is unable to afford private counsel, legal services are provided through a contract attorney and/or through the Disability Law Center.

8.2 Patients have the right to contact a legal representative by phone or sealed mail.

9. Patient Advocate. Patients have access to the patient advocate provided by the hospital.

10. Individualized Treatment. Each patient receives individualized treatment.

10.1 Each patient has the right to collaborate with his/her physician in making decisions involving his/her treatment.

10.2 Each patient is provided an individualized treatment plan.

11. Review of Treatment Plan. Patients may request an in-hospital review of their individual comprehensive treatment plan.

12. Participation in and Access to Information Regarding Treatment. Patients may exclude relatives, friends, and others not officially connected with the hospital from participating in and having access to information regarding their treatment.

13. Access to Contents of Medical Records. Patients may meet with a member of the hospital clinical staff, at a scheduled meeting, to discuss the contents of his/her medical records.

14. Opinion of Consultant. Patients may request the opinion of a consultant of their own choosing at their own expense.

15. Medication Treatment. Patients are informed of the risks, side effects, and benefits of all medications and treatment procedures used.

15.1 Patients are informed of alternate treatment procedures available.

15.2 Patients have the right, to the extent, permitted by law, to refuse specific medications or treatment procedures.

15.3 The Utah State Hospital has the responsibility to seek appropriate legal alternatives or orders of involuntary treatment, or, in accordance with professional standards, to terminate the relationship with the patient upon reasonable notice.

16. Pain. Patients have the right to be assessed and treated appropriately for pain complaints.

17. Advance Directives. Patients have the right to receive information regarding and to execute advance directives. (See: Patient Rights, Subsection: Advance Directives/Personal Choice/Living Will)

18. Informed Consent. A written, dated, and signed consent form is obtained from the patient or the patient's legal guardian for participation in research projects and for use or

performance of:

- 18.1 surgical procedures;
- 18.2 electroconvulsive therapy;
- 18.3 unusual medications;
- 18.4 hazardous assessment procedures;
- 18.5 audiovisual equipment; and
- 18.6 other procedures where consent is required by law.

19. Confidentiality. Utah State Hospital staff are responsible for maintaining the confidentiality of communications between patients and staff and of information recorded in patient records.

- 19.1 Patients may refuse student access to his/her medical record.
- 19.2 Patients may not record or photograph other patients.

20. Communication by Mail. Patients have the right to communicate by sealed mail or otherwise with persons, including official agencies, inside and outside the facility.

21. Communication by Telephone. Patients have the right to conduct private telephone conversations with family and friends, unless clinically contra-indicated.

- 21.1 Telephone access is within each unit's guidelines.

22. Visitors. Patients have the right to receive visitors in accordance with the hospital's visiting policy. (See Patient Management, Section: Visitors)

- 22.1 In no event is a patient's legal counsel or legitimate clergy denied a visit.

23. Exercise of Religious Beliefs. Patients have the right to exercise their religious beliefs and to participate in religious services at the hospital.

- 23.1 This right may be modified according to clinical indication as determined, documented, and approved by the clinical staff responsible for the patient's treatment and by the hospital chaplain.
- 23.2 Patients are not coerced or forced to engage in religious activity.

24. Possession of Personal Items. Patients may wear their own clothing, keep personal possessions, and keep enough personal funds for small day-to-day purchases.

25. Voting. Patients have the right to vote in accordance with Utah State Code.

26. Contractual Relationships and Purchasing. Patients have the right to enter into contractual relationships and to make purchases, except as psychiatrically contra-indicated for treatment purposes, or as may be limited on the basis of legal competence as determined by a court of law.

27. Personal Property. Patients have the right to dispose of personal property, except as psychiatrically contra-indicated for treatment purposes, or as may be limited on the basis of legal competence as determined by a court of law.

28. Citizen Participation. Patients have the right to citizen participation, except as psychiatrically contra-indicated for treatment purposes, or as may be limited on the basis

of legal competence as determined by a court of law.

29. Disposition of Body After Death. Patients have the right to determine the disposition of their body after death.

30. Ethical Issues. Patients have the right to participate in the consideration of ethical issues that arise in their care.

31. SuggestionGrievance Program. Patients have the right to initiate a complaint, grievance, or suggestion procedure and the appropriate means of review of the complaint or suggestion. (See Patient Rights, Section: SuggestionGrievance Program)

32. Communication with Mental Health Centers. Civilly committed patients have the right to periodically speak to a representative of the mental health agency to which they are committed.

33. Writ of Habeas Corpus. Patients are entitled to the writ of habeas corpus upon proper petition by himself or a friend to the district court in the county in which he is being detained.

34. Rights of Patient's Guardian. To the extent permitted by law, a patient's legal guardian may exercise the rights delineated on behalf of the patient if the patient has been adjudicated incompetent or is a minor.

35. Industrial Assignments. Patients may work for the hospital, as part of the Industrial Program, under the following condition:

35.1 any wages paid to the patient who is working within the program are in accordance with applicable laws and regulations;

35.2 the work is part of the patient's individual treatment plan; and

35.3 the work is performed voluntarily.

35.4 Patients are encouraged as part of the therapy process to engage in tasks that will help them in their skill development. Patients have the right to perform or refuse to perform the tasks in or for the hospital.

36. Discharge. Patients have the right to be discharged from the hospital when they and their treatment team feel it is appropriate and when adequate services are available in the community.

37. Denying or Limiting Rights. Patients are informed immediately when a right is taken away or limited and are given an explanation of why the right was taken away or limited.

37.1 Rights may be limited or taken away for "good cause" reasons which include:

37.1.1 it poses a danger to self or others;

37.1.2 it would seriously infringe on the rights of others;

37.1.3 it would pose serious damage to the facility; and/or

37.1.4 it is determined to be therapeutically contra-indicated.

37.2 When any right is limited or denied, the nature, extent, and reason for that limitation or denial is entered into the patient's treatment record.

37.2.1 When applicable and legal, the family member(s) are informed of the restriction and documentation is made.

38. Policies concerning patient limitations and the review of those limited are addressed in USHOPP Chapter: Special Treatment Procedures, Section: Restrictions and Limitations of Patient Rights.

Revised: 6-92
Revised: 5-93
Reviewed: 9-95
Revised: 12-98
Revised: 11-01

Chapter: ^{xlv} Patient Rights

(RI)

Section 2: Sexual Relations Between Patients

Policy

Sexual relations between patients are discouraged. This activity may aggravate problems the patients have and may victimize patients who are vulnerable.

Procedure

1. Appropriate supervision is provided by staff to restrict the opportunity for sexual acting-out by patients.
2. Romantic involvement between patients is discouraged.
 - 2.1 In the event that a romantic involvement occurs, strict monitoring and structure is provided to the patients involved.
3. Opportunities to develop meaningful relationships, including supervised dances, activities, and informal gatherings are provided.

Implemented: 5-18-87

Revised: 12-23-88

Reviewed: 3-92

Reviewed: 9-93

Revised: 11-98

Reviewed: 6-01

Chapter: ^{xlvi} Patient Rights

(RI)

Section 3: SuggestionConcern Program

Policy

Utah State Hospital recognizes and respects the opinions of the patients, visitors, and employees and has a SuggestionConcern Program that acknowledges concerns and suggestions from patients. All patients, visitors, and employees may express concerns without fear of reprisal from the staff or administration. All concerns and suggestions are reviewed by the Suggestion Committee. Each person submitting a concern or suggestion receives a response to those concerns.

Procedure

1. SuggestionConcern forms are located on each unit and in the Owen P. Heninger Building. Forms are also available on the USH web page.
 - 1.1 SuggestionConcern forms contain a place for the patient, visitor, or employee to check if it is a concern or suggestion.
 - 1.2 Patients, visitors, or employees may submit anonymous SuggestionsConcerns.
2. Each completed SuggestionConcern form may be placed in a locked Suggestion Box located on each unit and in the Heninger Administration Building.
 - 2.1 As part of patient orientation, each newly admitted patient receives a copy of the Patient Rights Statement which explains the suggestionconcern process.
 - 2.2 Patients who are unable to write their suggestionconcern may express it verbally to the Patient Advocate or a designated member of the Suggestion Committee.
3. The Patient Advocate collects the suggestionconcern forms from the Suggestion Boxes weekly.
4. All suggestionconcern forms are reviewed by the Suggestion Committee.
 - 4.1 The Suggestion Committee meets weekly.
 - 4.2 The Suggestion Committee assigns specific personnel to follow-up and respond to each suggestionconcern.
 - 4.3 Minutes are kept of Suggestion Committee meetings.

5. Individuals who submit a suggestionconcern receive a letter stating that the concern has been reviewed by the Suggestion Committee and has been forwarded to a specific person for follow-up.
6. Individuals assigned to follow-up on a patient statement of concern have seven working days to respond.
 - 6.1 Responses are made in writing and are forwarded to the Suggestion Committee Secretary.
 - 6.2 Responses are reviewed by the Suggestion Committee for completeness.
 - 6.3 Individuals who submit a statement of concern receive written documentation indicating that a response to their concern has been received, that the response has been reviewed by the Suggestion Committee, and the decision of the committee.
 - 6.4 All suggestionconcern forms and responses are recorded and filed in the Quality Resource office.
7. If the individual finds the response from the Suggestion Committee to be unsatisfactory, heshe has the right to appeal to the Hospital Clinical Director or designee.
8. If the individual finds the response from the Hospital Clinical Director or designee to be unsatisfactory, heshe has the right to appeal to the Hospital SuperintendentCEO or designee.
9. If the individual finds the response from the Hospital SuperintendentCEO or designee to be unsatisfactory, heshe has the right to appeal to the Disability Law Center, the hospital contract attorney, or a private attorney of hisher choice.

*Implemented: 4-92
Reviewed: 9-93
Revised: 12-98
Revised: 2-02*

Chapter: ^{xlvi} Patient Rights

(RI)

Section 4: Explaining Patient Rights on Admission

Policy

All patients shall receive an explanation and a copy of the Patient Rights upon admission.

Procedure

1. The Patient Rights and Patient Rights Statement are included in the admission packet.
2. The patient keeps the copy of the Patient Rights, and a signed Patient Rights Statement is filed in the patient's chart in the identification section.
3. If the patient does not appear to understand the Patient Rights, admitting personnel records this in the admitting progress note, and notifies the patient advocate for follow up.
4. Any questions patients have about Patient Rights that cannot be explained to the patient's satisfaction are referred to the Patient Advocate by phone or by leaving a note in a Suggestion Box.

*Implemented: 4-92
Reviewed: 9-93
Revised: 1-98
Revised: 11-01*

Chapter: ^{xlvi} Patient Rights

(RI)

Section 5: Advance Directives, Personal Choice, Living Will

Policy

Utah State Hospital, in compliance with the UCA 75-2-1101, et al, provides to each adult patient upon admission written information concerning the right to make binding written directives instructing physicians and other providers of medical services to withhold or withdraw, or to provide only to the extent set forth in a directive, life-sustaining and other medical procedures in the event of a terminal condition.

Definitions

1. Advance Directive is a document in which a person states choices for medical treatment or designates who (designee must be 18 years or older) should make treatment choices in the event of a terminal condition. Advance directives include "living wills" and durable powers of attorney for health care.
2. Terminal Condition is a condition caused by injury, disease, or illness, which regardless of the application of life-sustaining procedures, would within reasonable medical judgement produce death, and where the application of life-sustaining procedures would serve only to postpone the moment of death of the person.

Procedure

1. Documentation of Patient Advance Directive. Upon admission to Utah State Hospital, each adult patient and/or legal guardian is asked if he has executed an advance directive. The patient's response is recorded on form #USH0001, Documentation of Patient Self Determination Act and filed in the patient's medical record. A copy is provided to the Legal Services Department.

1.1 If, in the opinion of the admitting physician, information concerning advance directives would not be in the best interest of the patient, the physician documents this on the Advance Directive/Living Will Form.

1.2 When the patient becomes able, in the opinion of the attending physician, to receive information concerning advance directives, it is provided to him/her.

1.2.1 A copy of the Self Determination Act form is sent to Legal Services for tracking.

1.2.2 For those patients who the physician determined should not

receive information regarding Advance Directives, Legal Services will send out a new Determination Act to the physician to be reassessed after six months.

2. Advance Directive Filed in Medical Record. If the patient states that he has executed an advance directive, he is asked to provide Utah State Hospital with a copy. The advance directive is placed in the patient's medical record and a copy is forwarded to the Legal Services Department.

2.1 The attending physician(s) is informed of the advance directive and cooperates, in the event of a terminal condition, with the circumstances set forth therein.

2.2 If the patient cannot provide a copy of his advance directive to Utah State Hospital, the social worker contacts the referring agency, family, or personal representative to determine if a copy can be obtained.

2.3 If a copy of the directive is not available, the staff informs the patient that he may execute a new one.

3. Information Provided to Patient. All newly admitted adult patients are provided with information about advance directives. If the patient has questions or desires more information, including forms, he is referred to the patient advocate and/or patient legal counsel.

4. Discrimination. No patient is discriminated against, with respect to medical care or treatment, based on whether he has executed an advance directive.

5. Conflicts in Decision Making. All conflicts regarding decision making about the withholding of resuscitative services or for withdrawing life-sustaining services from an individual are referred to the hospital clinical director and/or the hospital ethics committee.

6. Directives Executed in Another State. Advance directives executed in another state are enforceable in Utah only to the extent they are consistent with Utah Law.

7. Patient Current Desires. The current desires of a patient, who is considered competent by the attending physician, at all times take precedence over and supersede any contrary directions in earlier signed directives.

8. Transfer of Patient. In the event that a patient, who has executed an advance directive, is transferred to another facility, the patient's treatment unit provides a copy of the advance directive to the receiving facility.

9. Revocation. In the event that a patient chooses to revoke his advance directive, he informs the staff by tearing, defacing, or by otherwise destroying the directive and/or by completing form #USH0002 Revocation of Advance Directive.

10. Education of Utah State Hospital Employees. Utah State Hospital provides written information to employees regarding the hospital's policies concerning advance directives.

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Revised: 6-01

Chapter: ^{xlix} Pharmaceutical Services (PH)

Section 1: Pharmaceutical Services

Policy

The Utah State Hospital provides an organized pharmaceutical service to meet the needs of the patients. The service is conducted in accordance with accepted ethical and professional practices and meets all legal requirements.

Procedure

1. Scope of Service.

1.1 Utah State Hospital Pharmacy provides services for all patients at Utah State Hospital. Services include, but are not limited to the following:

- Drug distribution (interpreting, clarifying, and processing medication orders);
- Providing drug-information service;
- Providing in-services to hospital personnel when needed;
- Participating in Quality Improvement programs;
- Participating in hospital committees, both regular and *ad hoc*;
- Participating in all JCAHO-mandated activities.

1.2 Utah State Hospital Pharmacy Services dispenses all medications prescribed by Utah State Hospital authorized prescribers for all Utah State Hospital patients. The majority of medications dispensed are antipsychotics, antidepressants, anxiolytics, and other medications frequently used in the treatment of psychiatric illness. The pharmacy also provides medications used in general medicine.

1.3 Most medications are dispensed to individual patients. Others such as concentrates and injectables are dispensed as ward stock to minimize waste. Schedule II, III, IV, and V controlled drugs are dispensed as ward stock, except when prepared as leave meds for individual patients. Other items approved as ward stock by the P&T Committee are also dispensed (e.g. antacids, rubbing

alcohol, povidone-iodine, sunscreen lotions, throat lozenges).

1.4 Pharmacy Services dispenses medications from a centralized location in the Medical Services Buildings. A central drug cabinet for after-hours use is maintained in the Hyde Building.

1.5 USH pharmacy functions as a resource for providing drug information to other health-care providers in the hospital. Pharmacists work and counsel with the nursing staff regarding the care of medication areas throughout the hospital in compliance with standards.

1.6 Pharmacists serve on hospital committees, and participate in all JCAHO-mandated activities.

1.7 The USH pharmacy is open Monday through Friday from 0800 to 1800. A pharmacist is not officially on call after hours, but can provide services after hours if notified. In addition, arrangements have been made with UVRMC Pharmacy to provide medications after hours, if a USH pharmacist cannot be reached in an emergency situation.

2. The scope of pharmaceutical services is reviewed annually and revised according to changing hospital needs and standards. Policies and procedures are established by the Director of Pharmacy Services, in combined effort with medical staff and nursing, and are revised when appropriate.

3. Pharmacy staff includes one full-time Director of Pharmacy, two full-time staff pharmacists, and two full-time pharmacy technicians. The pharmacy department occasionally uses light-duty personnel to perform clerical work. Pharmacy technician students may also be used as volunteer workers. The Pharmacy Director verifies credentials of all volunteer workers.

3.1 All pharmacists are graduates of colleges of pharmacy accredited by the American Council on Pharmaceutical Education, and are licensed by the Utah State Department of Business Regulations to practice pharmacy in the State of Utah and to dispense controlled substances listed in schedules 2, 2N, 3, 3N, 4, and 5.

3.2 All pharmacy technicians are licensed by the Utah State Department of Business Regulations, as required by Utah Law.

3.3 Pharmacists and pharmacy technicians fulfill all continuing pharmaceutical education requirements required by law to renew Utah licenses.

3.4 Licenses of Utah State Hospital Pharmacy, pharmacists, and pharmacy technicians are kept current as required by law, and are displayed in the pharmacy department. Copies of current licenses of pharmacists and pharmacy technicians are also kept in individual personnel files in the Human Resources Office.

4. The Pharmacy department is licensed as a pharmacy by the Utah Department of Business Regulations to perform any and all pharmaceutical functions including regulating and dispensing controlled substances listed in schedules 2, 2N, 3, 3N, 4, and 5.

5. When the pharmacy is closed (e.g. evenings and weekends), nurses should obtain medications from ward emergency stock or their Hope Unit central emergency

cabinet located in the Hyde Building. If the medications are not available from these sources, nurses should contact the switchboard to call one of the pharmacists. If, after a reasonable period of time, a pharmacist cannot be reached, or in the event of a clinical emergency, it is permissible to call the pharmacy at Utah Valley Regional Medical Center at 375-7051 to request the medication. When obtaining medication from UVRMC, the following procedure is used:

- 5.1 The person requesting the medication must identify him or herself to the UVRMC pharmacist on the telephone and request the needed medication.
- 5.2 A copy of the medication order must be taken to UVRMC Pharmacy to verify the order. If the order is for a controlled substance, a copy of the original order must be left with the pharmacist at UVRMC. If the order is for a schedule-II controlled substance, an original order signed by the prescriber must be given to the pharmacist at UVRMC.
- 5.3 The person obtaining the medication from UVRMC must show appropriate identification.
- 5.4 A copy of the charge slip must be sent to the USH pharmacy the next day the pharmacy is open.
6. The pharmacy department maintains adequate space, equipment, supplies, and environmental conditions to function within the scope of services the present organizational structure requires.
 - 6.1 Areas for offices, computer workstations, library/conference room, storage, compounding, and dispensing of medications are present.
 - 6.2 Adequate office equipment is present, including desks, computers, printers, copy machine, telephones, paper, labels, etc.
 - 6.3 Refrigerators are present, with food stored separately from refrigerated pharmaceutical products.
 - 6.4 A laminar-flow hood is kept in the pharmacy. IV admixture, when performed by a pharmacist, is done in a laminar-flow hood. Use of products requiring IV admixture is discouraged. Most preparations for IV use are obtained in the *Add-Vantage* dosing system, which allows preparation on the nursing unit without the use of a laminar-flow hood.
 - 6.5 Environmental conditions are maintained in such a way as to allow proper temperature, light, humidity, and other conditions necessary for proper storage of medications, according to the pharmaceutical manufacturers' requirements and recommendations.
 - 6.6 The pharmacy department maintains updated and pertinent reference materials. Pharmacy reference materials include, but are not limited to, *Drug Facts & Comparisons* (which is updated monthly), a current edition of *AHFS Drug Information, Facts & Comparisons*, *The Review of Natural Products* (which is updated monthly), *Remington's Pharmaceutical Sciences*, *USPNF*, and a copy of current Utah laws governing pharmacies and pharmacy practice.
 - 6.7 The pharmacy library contains current reference books and professional journals, which are available for use by all USH healthcare providers. Publications may not be removed from the library, except by permission from the

department director.

7 The Director of Pharmacy Services, with assistance from staff pharmacists and nurses, establishes and maintains medication areas throughout the hospital that are appropriate for storage, preparation and administration of medications. The following conditions are considered necessary:

7.1 Internal medications are stored separately from injectable and external preparations in all medication areas.

7.2 Medication areas are maintained in a manner to insure that drugs are stored under proper conditions (away from excess light, heat, moisture, or temperature extremes) in all locations, with attention given to those drugs that must be kept frozen or refrigerated, or in any special manner prescribed by the USPNF and/or manufacturer. All drugs are stored so as to insure full potency and effectiveness.

7.3 Outdated and unusable drugs found on the treatment units are removed from the shelves immediately and returned to the pharmacy for replacement or disposal. Outdated drugs are stored by the pharmacy in an area designated by the Director of Pharmacy, and are returned to manufacturer or vendor for credit when appropriate. Unusable medications or non-returnable outdated medications are destroyed in the pharmacy.

7.4 All medication areas (med rooms) are inspected on a regular basis by a pharmacist to certify that proper conditions for storage, preparation, and administration of medications are present.

7.5 Controlled substances are prepared, dispensed, and administered in a manner consistent with existing federal and state laws and regulations. Copies of applicable laws are on file in the pharmacy. The proper documentation, distribution, and administration of controlled-substances in the pharmacy and on nursing units is routinely checked by a pharmacist.

7.6 Emergency drugs and antidotes are stocked on the units. The Pharmacy and Therapeutics Committee, acting with the medical staff is responsible for designating the drugs to be stocked, where they are to be stocked, and the quantities to be stocked.

7.7 Emergency kits that have been approved by the medical staff and the Pharmacy and Therapeutics Committee are stored on each unit. The contents and quantities of the emergency kit are listed on the lid of each kit and also inside of the kit. The expiration date for the kit is written on the box label, and is the expiration date for the item that outdates first. Each emergency kit is checked periodically by a pharmacist, according to its expiration date. Whenever the lock is broken, regardless of usage of contents, the kit must be returned to the pharmacy to be restocked (when necessary), inspected, and re-locked with a seal containing a serial number. The expiration date of the kit contents, and the serial number of the seal are recorded in the pharmacy.

7.8 The metric system is used exclusively at USH, and conversion charts (metric-apothecary) weights and measures are provided by the pharmacy. Copies of conversion charts may be obtained from the pharmacy.

8. All drugs, chemicals, and biologicals meet national standards of quality as listed in the Food Drug Administration publication "Approved Drug Products." Drugs that have

been approved by the medical staff through the Pharmacy and Therapeutics Committee are used in accordance with written hospital policies and procedures. Drug distribution must meet all applicable federal and state laws and regulations.

8.1 The Director of Pharmacy is responsible for the development of written policies and procedures that govern safe storage, preparation, distribution, and administration of drugs according to applicable federal, state, and local laws and regulations.

8.2 An adequate drug supply is maintained by anticipation of future needs based upon past usage.

8.3 Antidotes and other emergency drugs approved by the medical staff and P&T Committee are available in emergency kits and drug cabinets located on the units. Emergency kits and cabinets are labeled as to contents. Pharmacy also keeps lists of approved contents for cabinets and emergency kits.

8.4 Poison control telephone numbers are placed on most telephones in medication areas, and on hospital ID badges. In the event of a poisoning, the poison control center should be immediately contacted for advice and recommendations. When appropriate, the local paramedics may be called, and/or the patient transported to Utah Valley Regional Medical Center.

8.5 The director of pharmacy directs the review, processing, labeling, and dispensing of all medication orders sent to the pharmacy.

8.5.1 Only a pharmacist may review, process, and enter new written medication orders into the computer system. Only a pharmacist may review and process electronic orders entered by authorized prescribers or their agents (e.g. a verbal orders entered by a nurse). All new medication orders, electronic or written, must be reviewed by a pharmacist for appropriateness in terms of diagnosis, choice of medication, dose, dosage form, drug-drug interactions, or any other pertinent criteria. Any questions or potential problems must be resolved by a pharmacist with the prescriber.

8.5.2 Under the direction of a pharmacist, pharmacy technicians may process requests for reorders, leave meds, ward stock, and dispense and label medications. All order processing, dispensing, and labeling performed by a pharmacy technician is checked by a pharmacist before medications leave the pharmacy.

8.5.3 All leave medications (e.g. for home visits, court visits, trial leave, or discharge) processed, dispensed, or labeled by a pharmacist must be double-checked by another pharmacist before they leave the pharmacy.

8.6 Records of pharmacy transactions are kept in accordance with federal, state, and local laws. Adequate control and accountability of all drugs is maintained. This includes a system of controls and records for the requisitioning and dispensing of pharmaceutical supplies to nursing care units and to other departments of the hospital.

8.7 The pharmacy distributes ward stock supplies to nursing areas. A medication nurse uses a pharmacy-designed ward stock list to order necessary supplies.

8.8 The ward stock list is developed by the pharmacy, and presented to the Pharmacy and Therapeutics Committee and medical staff for approval. The list is updated when new drugs are added or deleted by the Pharmacy and Therapeutics Committee.

8.9 Utah State Hospital uses an open formulary. Medications routinely stocked by the pharmacy are listed in the e-chart formulary. This list is routinely modified according to need. When a specific medication is needed, but not routinely stocked by the pharmacy, a pharmacist may acquire the medication from another source such as our prime vendor, other pharmacies, local hospitals, or drug companies.

8.10 When medications are used from any of the after-hours cabinets, or emergency kits, their use is documented on an emergency-medication billing form, which is sent to the pharmacy the next working day. This form is used to replenish stock that has been used.

8.11 The pharmacy maintains electronic and written records of all medication orders processed for Utah State Hospital patients, in accordance with applicable federal and state law regulations.

8.12 Strict patient confidentiality is maintained regarding electronic or written records. Documents or labels containing patient names or information are shredded before being discarded. Labeled bottles containing patient names are also shredded before being discarded. Labeled containers that cannot be destroyed by shredding have their labels removed and shredded.

8.13 When notice of medication recalls by pharmaceutical manufacturers or other vendors are received by the pharmacy, pharmacy and other hospital stock will be checked for presence of medication being recalled. If such medication is present, it shall be returned to the manufacturer or vendor according to the instructions in the recall notice. Records of any recalled medications returned by Utah State Hospital shall be kept in the pharmacy for at least one year.

8.14 Pharmacists report drug problems and unexpected adverse reactions to Division of Epidemiology and Drug Experience (HFD-210) Food and Drug Administration, 5600 Fishers Lane, Rockville, Maryland 20857. Reports may also be entered at the FDA web site.

8.15 All pharmaceutical samples obtained by prescribers for use at Utah State Hospital must be sent to the pharmacy for distribution. Samples intended for use outside Utah State Hospital must be removed from the premises.

9. The Director of Pharmacy directs the review, processing, labeling, and dispensing of all medication orders sent to the pharmacy.

9.1 Only a pharmacist may review, process, and enter new written medication orders into the computer system. Only a pharmacist may review and process electronic orders entered by authorized prescribers or their agents (e.g. a verbal order entered by a nurse).

9.2 All new medication orders, electronic or written, must be reviewed by a pharmacist for appropriateness in terms of diagnosis, choice of medication, dose, dosage form, drug-drug interactions, or any other pertinent criteria. Any questions or potential problems must be resolved by a pharmacist with the prescriber.

9.3 Under the direction of a pharmacist, pharmacy technicians may process requests for reorders, leave meds, ward stock, and dispense and label medications. All order processing, dispensing, and labeling performed by a pharmacy technician is checked by a pharmacist before medications leave the pharmacy.

9.4 All leave medications (e.g. for home visits, court visits, trial leave, or discharge) processed, dispensed, or labeled by a pharmacist must be double-checked by another pharmacist before they leave the pharmacy.

9.5 All prescriptions are prepared and dispensed according to acceptable standards and ethics of the pharmaceutical profession. The medications are kept clean and dispensed in sanitary containers with appropriate labeling which includes cautionary labels as needed. Expiration dates are included when appropriate.

9.6 Only a pharmacist, or a pharmacy technician under supervision of a pharmacist, makes labeling changes or transfers medications to different containers.

9.7 Only pharmacists have keys to the pharmacy. No other persons are authorized to enter or remove drugs from the pharmacy. A pharmacist must be present and in charge at all times when the pharmacy is open.

9.8 Leave medications, such as those sent for home visits, court visits, or discharge, are dispensed from the pharmacy in child-proof containers (when legally required), and contain the following information:

prescription number, name of prescriber, medication name, medication strength or concentration, quantity dispensed, patient's name, date dispensed, dosing instructions, cautionary or warning labels if appropriate, pharmacy name, address, and telephone number.

In the event that leave medications are required, and pharmacy preparation of medications before the patient leaves is not feasible (e.g. evenings, weekends, or holidays when pharmacy is closed), a nurse may package the medications in envelopes from existing unit supplies, providing the following criteria are met:

9.8.1 The supply sent with the patient does not exceed a 72-hour supply;

9.8.2 Medication envelopes are legibly labeled with patient's name, medication name, medication strength or concentration, quantity, and dosing directions;

9.8.3 when possible, all medications for one dosing time (e.g. AM, noon, PM, or HS) should be consolidated into a single envelope to simplify dosing, and encourage patient compliance with dosing directions. In this case the envelope would be labeled with patient's name, medication name(s), medication(s) strength or concentration, and quantity or quantities contained in the envelope. The dosing directions would give the day and time the entire contents of the envelope were to be taken or administered, plus any special instructions if appropriate.

9.8.4 Camp trip and activity medications are prepared and administered by the RN attending the camp trip or activity. Medications may be

prepared in envelopes with the patient's name, medications and dose; and the date and time to be given. All medications for one dosing time should be consolidated into one envelope to simplify dosing as mentioned in 9.8.3. Medications for hospital-wide camp trips or activities that are prepared by the unit nursing staff must be verified by the RN attending the activity or camp trip before sealing the envelope.

10. Policies and procedures for proper administration of medications is detailed in the Medication section and Nursing section.

10.1 Drugs are administered only upon an order of an authorized prescriber, and verbal orders are accepted only by personnel that have been designated in the medical staff rules and regulations. Verbal orders are signed by the prescriber within a seven day time period.

10.2 All medications are prescribed by appropriately licensed personnel in accordance with existing laws and with approved medical staff rules and regulations. See pharmacy guidelines for authorized prescribers.

10.3 Only licensed physicians, registered nurse practitioners, registered nurses, and licensed practical nurses are authorized to administer medications at Utah State Hospital.

10.4 Drugs to be administered are verified with the prescribers' orders, and are prepared appropriately for administration. The patient is identified prior to administration of the drug, and each dose is recorded in the patients' medication administration record. Controlled substances administered are also recorded on special forms as detailed in Nursing section.

10.5 Telephone orders are permitted only by authorized prescribers, and then only in emergency situations. An emergency situation with regards to telephone orders is defined as a situation in which "the prescriber is on hospital grounds, but the patient's chart is not readily available to the prescriber, or a situation in which the prescriber is off hospital grounds, such as evenings or weekends." Only registered nurses are authorized to accept telephone orders for prescriptions. The nurses shall write verbal orders in the patients' charts immediately, or enter them into e-chart via computerized order entry. An authorized prescriber signs the charted telephone orders or acknowledges electronically-entered orders within 7 days.

10.5.1 When a verbal medication order is given, the RN receiving the order immediately repeats it back to the prescriber to assure accuracy.

10.6 A list of hospital-approved abbreviations and chemical symbols is posted in the medication areas of the Utah State Hospital, and authorized staff use only these standard abbreviations when writing.

10.7 There are automatic stop orders on specified medications. The Pharmacy and Therapeutics Committee determines which medications shall have automatic stop orders, and the time period for such stop orders.

10.8 Patients and/or responsible parties are instructed on the medications that are to be taken home. The instructions relate to dosages, need for compliance, warnings and precautions, special storage, and any other appropriate information. When patients are transferred to mental health centers, prison, nursing homes,

etc., a medication letter is sent with details of proper administration. See Patient Management Manual.

10.9 The nursing staff documents all medications administered, medication errors, and suspected adverse drug reactions. Pharmacy documents known errors and suspected adverse drug reactions. Details are found in the pharmacy guidelines and Patient Management Manual.

10.10 Laboratory procedures and visual methods are employed in detecting drug side effects and/or toxic reactions. Lithium and anticonvulsant and other critical drug levels are taken as ordered by the physician or nurse practitioner.

10.11 Drugs that are brought into the hospital by patients are returned to the responsible party when possible. When there is no responsible party, the drugs are sent to the pharmacy for destruction. The drugs brought in by patients are of questionable integrity and sometimes inappropriate. However, when the pharmacy is closed and needed medications are not available in hospital emergency supplies, drugs brought into the hospital by a patient may be used only on a temporary basis, if they can be positively identified (preferably by more than one individual), and only if approved by the responsible physician.

10.12 Herbal preparations (also called "nutraceuticals"), are classified by the FDA as dietary supplements. If these preparations are brought into the hospital by patients, or requested by patients, their use must be approved by an authorized prescriber via a medication order. Before these preparations are ordered, their use should first be screened for appropriateness, potential drug-drug interactions, and other warnings or precautions. Pharmacy Services keeps current reference material for herbal preparations, and pharmacists will provide reference material and/or evaluate orders for herbal preparations when requested.

10.13 Utah State Hospital allows the self-administration of selected medications. When self-administration is appropriate, it is approved by the physician and is supervised by a registered nurse or a licensed practical nurse.

10.14 Pharmacy is provided with a list of authorized prescribers and dispenses only those prescriptions written and/or authorized by a physician on this list. When a patient visits a physician whose name is not on the list, the unit physician shall authorize the medication(s) intended. The list of authorized prescribers is updated monthly by the Hospital Clinical Director and sent to the pharmacy for distribution to the units. The authorized prescriber list includes the state license number with expiration date and DEA number with expiration date.

11. Pharmacy Services, as part of the overall hospital quality-improvement program, regularly participates in quality improvement programs that relate to the quality and appropriateness of patient care.

11.1 The director of pharmacy in cooperation with pharmacy staff identifies areas for quality improvement. The APIE format (assess, plan, implement, and evaluate) is used. All members of the pharmacy department participate in quality improvement projects.

11.2 Reports of quality improvement projects are presented to the Quality Resources department, and any other appropriate individuals, committees, or departments. Problems are identified, discussed, and appropriate assignments are made to resolve them. The intended outcome is better patient care. The

pharmacy department will keep records of quality-improvements projects it has done.

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Chapter: ¹ Plan for Services (PN)

Section 1: Plan for Services

Hospital Overview

1. Governance.

1.1 Authority: The Utah State Hospital is a publicly funded, state-owned psychiatric facility. The hospital operates with funds appropriated annually by the Utah State Legislature and functions with the authority given it by state statute as designated in the Utah Code Annotated 1991; Section 62A-15-601 through 62A-15-647. Administrative authority is given by statute to the Division of Substance Abuse and Mental Health for maintenance and operation of the hospital. It is empowered to determine and maintain the objectives, purposes, and values of the hospital in order to assure that the accreditation and licensing requirements of the Joint Commission on Accreditation of Healthcare Organizations and the Utah State Department of Health are met and to appoint a superintendent/chief executive officer, and establish the qualifications, and duties of that position.

1.2 History: The Utah State Hospital was established by the Utah Territorial Legislature to serve the needs of the territory's mentally-ill and mentally-retarded citizens. The hospital opened in 1885 with a patient population of fifteen. Statehood, the railroad, and increasing population dictated immediate expansion, and two additional buildings were constructed by the turn of the century. By the 1930's three additional dormitories had been constructed, bringing the hospital bed capacity to its maximum of 1,260-although actual census reached 1,490 in the mid-1950's. The mentally retarded were removed from the hospital population in 1933 with the creation of the Utah State Training School. The development of psychotropic medication in 1955, coupled with the refinement of various therapeutic interventions, helped the hospital census to begin a significant decline from its peak of 1,490 patients to around 700 in the 1960's. This reduction in hospital size re-occurred with the opening of Utah's first public community mental health center in 1969 and continued with each regional center's development until 1973, when the census reached its lowest point of 280 patients. In 1974, in an effort to determine the hospital's role within the mental health system, the present specialized program areas were developed. Census did stabilize, and bed capacity has since increased, due to increasing need for inpatient intermediate psychiatric care not provided in the existing system for the state's adult civilly committed population. The licensed capacity of the hospital is 343. The hospital first became Joint Commission accredited in 1975. It has maintained this status

since that time, along with being certified by the federal Health Care Financing Administration in all of its program components.

1.3 Relationships: Organizationally, the State of Utah is administered by the Governor of the State. Under the Governor exist several departments of government. The Department of Human Services serves as the administrative link between the Division of Substance Abuse and Mental Health and the Utah State Hospital to the Governor. The Division of Substance Abuse and Mental Health has delegated authority to the hospital's Governing Body to establish the Medical Staff Organization; approve or disapprove bylaws, rules and regulations, appointments, non-appointments, and re-appointments; to assign, curtail, and/or terminate privileges; and to implement and monitor the quality improvement program. The Governing Body of the hospital consists of the Director of the State of Utah Division of Substance Abuse and Mental Health, the Hospital Superintendent, the Hospital Clinical Director, Hospital Medical Staff President, and a representative of the Department of Human Services. Authority is delegated from the Governing Body to the Hospital Executive Staff to manage the day-to-day operations of the hospital. The Superintendent reports all significant matters concerning hospital operations to the Governing Body at its regularly held meetings. It is also the responsibility of the Superintendent to represent and communicate for the hospital medical staff, professional discipline directors, and other clinical and administrative services of the hospital to the Governing Body.

2. Description of Hospital Role and Function.

2.1 Mission: The mission of the Utah State Hospital, as an active participant in the public mental health system, is to provide excellent inpatient psychiatric care. The hospital receives, evaluates, and provides treatment and rehabilitative services for those individuals committed to its care. It serves as an inpatient treatment facility for those individuals requiring a level of inpatient care not provided in the community and those individuals requiring specialized programs not found elsewhere. Individuals are returned to the community-based mental health agencies as soon as remission of their mental illness will allow and a less restrictive alternative is indicated. The following populations are served:

2.1.1 Civilly committed or voluntarily admitted adults having been referred from throughout the state *via* the public mental health centers.

2.1.2 Adult offenders admitted by court order for evaluation and/or treatment.

2.1.3 Children and adolescents having been referred for treatment by the public mental health centers or the child's parents and having been court committed or committed through a neutral and detached fact finder.

2.2 Patient Population: The hospital serves the entire State of Utah as its only state funded psychiatric hospital. All admissions of civilly committed and voluntarily admitted adults are coordinated through mental health centers which screen, evaluate, treat, and refer to Utah State Hospital when a less restrictive alternative and resource is not available. Those centers include Bear River, Weber County, Davis County, Salt Lake Valley, Wasatch, Central Utah, Four Corners, Northeast Counseling Center, San Juan County, and Southwest Utah. All civil beds at the hospital are allocated to the mental health centers, and admissions are coordinated through the Admissions (ADT) office. Once treatment

is completed at the hospital to the extent that the patient can again return to the community, the mental health center is responsible for finding suitable placement and completing the discharge plan as outlined by the hospital. The patient population consists of children ages six through twelve (Children's Unit), adolescents ages thirteen through seventeen (Adolescent Unit), and adults ages eighteen and older (Adult, Forensic, and Geriatric Units).

2.3 Scope of Services: The scope of services provided by the hospital is limited to those treatment modalities offered on an inpatient basis. Since the hospital is part of the state's public mental health system, all outpatient services are provided by the mental health centers. The specific services offered by the hospital include those provided by the hospital's professional staff, *i.e.*, psychiatry/medicine, nursing, psychology, recreation, social work, occupational therapy, vocational therapy, and substance abuse treatment. Ancillary services provided either by the hospital or via contract, include dental, dietetic, education, emergency, library, neurology, optometry, pathology and medical laboratory, pharmacy, podiatry, radiology, physical therapy, pastoral, hearing, speech, and language. In addition, consultative services from the community are available for ECT, orthopedics, OBGYN, cardiology, dermatology, ENT, gastroenterology, optometry, pediatrics, infectious disease, internal medicine, neurology, ophthalmology, podiatry, pulmonary medicine, general surgery, and urology.

2.4 Integration of Services: Many mental health disciplines and departments provide services to patients. A process is in place to see that these services are well integrated and to assure that each patient receives the individualized care he or she needs. This process provides the opportunity for each patient to take advantage of any services available in the hospital that are therapeutically indicated. Hospital services are integrated in the following ways:

2.4.1 Multidisciplinary treatment teams direct the treatment planning process for each patient. These teams consist of a psychiatrist, social workers, recreational therapists, nurses, and psychiatric technicians. If the patient is utilizing supplementary services such as vocational rehabilitation, occupational therapy, etc., a staff member representing the assigned service may also participate as a team member. These teams have the responsibility to see that each patient has a well defined treatment plan with access to any treatment modality that the patient requires. Treatment teams meet regularly to review patient progress, update treatment plans, and coordinate services. The treatment team is the organization which provides leadership in identifying needs for services that are not unit specific and makes referrals to obtain these additional resources.

2.4.2 Many services patients receive at the hospital are not provided by staff assigned to the patient's treatment unit. These ancillary and consultative services are listed above under the "scope of services" section. When the treatment team believes there is a need for services which are not available on a unit level, a referral is made to the appropriate department. An evaluation is completed by the department personnel and needed services are included in the patient's treatment plan.

2.4.3 The hospital has developed many avenues to facilitate communication and cooperation between individuals and departments. Meetings designed to fulfill this purpose include the executive staff meeting,

medical staff meeting, administrative services meeting, treatment team meetings, various discipline meetings, unit service management team meetings, unit staff meetings, and unit change of shift meetings. Many opportunities to share ideas about how to best use hospital resources to meet patient care needs are provided through regular hospital sponsored case conferences and workshops which are attended by staff members from the various disciplines and departments at the hospital. Other opportunities available to staff to facilitate communication and cooperation in providing integrated care include access to supervisors, use of the suggestion box program, weekly executive staff announcements, newsletters, and memoranda.

2.4.4 Utah State Hospital policy is developed through a collaborative process. Departments that are impacted by a policy participate in the development of the policy. Policies are approved through a multi-step process which allows people who represent all of the service areas of the hospital to give input on the proposed policy. Each policy is reviewed and approved by the administrative services, the medical staff, the executive staff, and the governing body.

2.5 Utah State Hospital Values Guiding Treatment and Patient Care: Utah State Hospital employees are committed to the belief that all hospital policies and procedures should be driven by and consistent with our value system. This value system includes the following:

2.5.1 Every individual, whether patient, employee, or member of the public, has worth and a right to be treated with dignity.

2.5.2 Every patient is entitled to individualized, active treatment which is consistent with current and progressive standards of care.

2.5.3 It is the responsibility of every employee to maintain current professional skills, honest work habits, and credibility with patients, taxpayers, and fellow employees.

2.5.4 The Utah State Hospital provides a secure, healthy, and comfortable environment.

2.5.5 The hospital functions as a unified whole relative to its philosophy, missions, and objectives.

3. Treatment Process.

3.1 All admissions to the Utah State Hospital are coordinated through the state mental health agencies or the criminal justice system, *i.e.*, no individuals are admitted directly to the hospital without referral. All civilly committed individuals are admitted to USH after having first been evaluated by the community mental health centers across the state. Individuals admitted to the Forensic Evaluation/Treatment Unit have been court ordered to these programs or transferred from the Utah State Prison as outlined in Utah Code Annotated. Children under age sixteen are here on a civil commitment on a commitment by a "neutral and detached fact finder" who determines the child meets commitment criteria per Utah Code Annotated. In those admitting situations which involve forensic cases or children, the referring agency or court works directly with the staff of the receiving unit to coordinate for space availability, needs of the patient,

history, etc. All civilly committed adult admissions are coordinated between the referring mental health center and the Hospital Admissions Office. The Admissions Office works with the treatment staff of the adult units to coordinate space availability, bed allocation, needs of the patient with programs of the unit, history, medical needs, etc. The multi-disciplinary team reviews all assessments and develops a provisional treatment plan within 72 hours and then an initial treatment plan for each treatment patient within the first fourteen days after admission. The treatment plan is reviewed by the multi-disciplinary team every thirty days. During this formal thirty-day review, the progress of the patient is assessed, along with the various therapies prescribed by the team. Appropriate changes are made in the plan to insure that treatment modalities are current and meet the needs of the individual patient. Discharge planning for the individual patient begins at the time of the formulation of the pre-admission assessment as release to a less restrictive setting is the goal for each patient admitted to USH. The patient's progress as per the discharge plan is reviewed every thirty days by the multi-disciplinary team. During the patient's treatment, representatives of the schools, mental health center, court, or other referring agency are made part of the planning process to insure continuity of care for the individual. Since USH provides no post-discharge program, it is imperative that therapy, financial, medical, living, and case management services are planned and arranged for the patient prior to his/her release.

4. Facilities.

4.1 Site: The Utah State Hospital is located in Provo, Utah. The site is slightly over 300 acres of beautiful campus landscaping. It is in east Provo at the foothills of the Wasatch Mountains which offers a very nice view of Utah County from our Castle Park area. The site was chosen in 1885 due to its central location in the state. It was originally an area secluded from the population of the busy cities but is now a valuable property dedicated to the mentally ill of the state.

4.2 Buildings: Present facilities and their dates of construction include the Owen P. Heninger Administration Building, 1981; Hyde Building-patient living complex, 1921; Youth Center School, 1950; Beesley Adolescent Center, 1985; Medical Surgical Building-containing the Children's Treatment Unit and School, 1930; Children's Enrichment Center-day-care facility, 1930; Chapel, 1970; the Lucy Beth Rampton Building-Adult Services, 1994; 100-bed Forensic Facility, 1999; and five buildings used for storage and maintenance related activities. The Castle, a patient recreation area built in 1936 as a WPA project, and the Castle Park, a beautiful picnic-recreation area consisting of a fish pond and pavilion for use by the patients, are also located on the hospital grounds. Long-range planning for the campus continues to focus on its development as a multi-purpose "reservation" for Utah's mentally-ill population. The Superintendent's Home and the Castle were added to the National Historical Register in 1986.

Hospital Staff Organization

Although the treatment units are individualized in relation to treatment staff and programs, the administrative and clinical policy development and supporting services are centralized to promote efficiency and common standards of care throughout the facility. The attached organizational chart reflects the relationship and lines of authority from the Governing Body through the Hospital Superintendent to each organizational unit. Each service area maintains its own Policy and Procedure Manual, which is complementary to

the USHOPP, and more specific to the service area.

1. Executive Staff.

1.1 Description: The Executive Staff of the hospital consists of the Superintendent, Hospital Clinical director, Assistant Superintendent, Assistant Clinical DirectorNurse Executive, and Nursing Administrator. All administrative and clinical services are organized and managed through these positions. They also serve to provide a communications link with the hospital at large through the Superintendent to the Governing Body.

1.2 Table of Organization:

1.3 Position Descriptions:

1.3.1 Hospital Superintendent: The Superintendent is given all the necessary authority and the responsibility to operate the hospital in all its activities by the Governing Body. The Superintendent acts as the duly authorized representative of the Governing Body in all matters pertaining to the daily operation of the hospital. The Superintendent appoints or employs the other members of the Executive Staff. (The Hospital Clinical Director is also approved through the Governing Body.) The Superintendent sees that all legal and moral responsibilities pertaining to the hospital, as described in statute, state policy, andor governmental rules and regulations are appropriately met. He acts as liaison with the Governing Body, State Board of Mental Health, state legislature, and the governmental offices with which the hospital interacts. He may delegate certain responsibilities to key members of his performance plan of those individuals, holding each accountable for those delegated functions.

1.3.2 Hospital Clinical Director: The Hospital Clinical Director serves as direct supervisor of the Assistant Clinical Director, Director of Medical Services, supervising psychiatrists, Medical Consultants, Quality Resource Director, directors of the professional disciplines, and any other physicians employed or providing services under contract. He directs the quality improvement activities of the medical staff, serves as Chairperson of the Medical Executive Leadership Group, and represents clinical staff in the Governing Body meetings.

1.3.3 Assistant Superintendent: The Assistant Superintendent assists the Superintendent and works with the Clinical Director in the organization, operation, and monitoring of Maintenance, Support Services, Security, Fiscal Services, Computer Services, Risk Management, Safety, Human Resources, Legal Services, the Chaplain, Volunteer Services, and Medical Records Manager.

1.3.4 Assistant Clinical Director: Assists the Clinical Director in the organization, operation, and monitoring of clinical programs throughout the hospital. Functions as the Nursing Executive and supervises the Nursing Administrators along with the nursing discipline. Supervises the unit administrative directors, the Admissions Officer, Patient Education Services, the Program Specialist, standing committees, and standards of certifying

bodies.

1.3.7 Nursing Administrator: See 2.3.6.

2. Hospital Clinical Management Staff.

2.1 Description: The clinical staff of the hospital consists of those positions reporting ultimately to the Hospital Clinical Director. Clinical services to hospital patients are organized and managed through these positions. They also serve to provide a communications link from the clinical services providers to the Hospital Clinical Director and through him/her to the Hospital Superintendent. The Assistant Clinical Director assists the Clinical Director in his duties.

2.2 Table of Organization:

2.3 Position Descriptions:

2.3.1 Hospital Clinical Director: See 1.3.2.

2.3.2 Assistant Clinical Director: See 1.3.4.

2.3.3 Director of Medical Services: Responsible, under the direction of the Hospital Clinical Director, for providing the diagnosis, treatment, and supervision of care in all medical matters for patients at the Utah State Hospital. This includes:

2.3.3.1 Providing admission physical examinations and annual updates.

2.3.3.2 Examination, diagnosis and treatment of all cases referred by the Unit Clinical Directors.

2.3.3.3 Referral of cases requiring consultation to the other medical practitioners.

2.3.3.4 Supervision of arrangements for admission of Utah State Hospital patients to other physical care facilities.

2.3.3.5 Supervision of medical care provided on all Utah State Hospital treatment units.

2.3.3.6 Supervision of the appropriate clinical function of all medical care consultants.

2.3.3.7 Supervision of all Nurse Practitioners in the performance of their clinical responsibilities.

2.3.3.8 Clinical supervision of Utah State Hospital staff in the performance of appropriate practice and functions of the Hospital Clinics (Dental, Podiatry, Neurology, Optometry, and Physical Therapy).

2.3.3.9 Advisor to the Clinical Director and Hospital Superintendent in all matters of physical medicine.

2.3.3.10 Member of appropriate hospital committees as assigned.

2.3.4 Supervising Psychiatrists: Supervising psychiatrists assist the Hospital Clinical Director in supervising other psychiatrists.

2.3.5 Unit Clinical Directors: Each of the treatment units has a psychiatrist assigned as the Unit Clinical Director. These physicians are directly supervised by the area supervising psychiatrists. As the designee of the Hospital Clinical Director on each unit, they are responsible for all clinical care, including admission and discharge.

2.3.6 Nursing Administrator: Serves as the chief nursing consultant and provides leadership in the development and direction of the clinical nursing services programs. Ensures that discipline members have appropriate license and clinical privileges. Responsible for discipline peer review and for the quality and appropriateness of the patient care provided by the nursing staff. Has direct responsibility for the clinical supervision of UNDs, RNs, LPNs, laboratory services, and psychiatric technicians.

2.3.6.1 Assistant Nursing Administrator: Provides administrative supervision to SSRNs, Medical Ancillary Services, including sterile supply, radiology services, dental services, and hospital clinics.

2.3.6.2 RN Shift Supervisors: Responsible for supervision of all hospital staff on shifts when the Administrative Staff is not present, *i.e.*, evenings, weekends, *etc.*

2.3.6.3 Nursing Administrator of Education: Serves as the chief educator and provides leadership to education office staff and clinical nurse specialists.

2.3.7 Director of Psychology Services: Serves as the chief psychology consultant and provides leadership in the development and direction of the clinical psychology services programs. Ensures that discipline members have appropriate license and clinical privileges. Responsible for discipline peer review and the quality and appropriateness of the patient care provided by the psychology staff.

2.3.8 Director of Social Work Services: Serves as the chief social work consultant and provides leadership and direction in the development of the Social Work Program. Responsible to insure that members have the appropriate license and clinical privileges. Responsible for discipline peer review and the quality and appropriateness of the patient care provided by the social work staff.

2.3.9 Director of Activity Therapy Services: Serves as the chief activity therapy consultant and provides leadership in the development and direction of the Activity Therapy Services Programs. Ensures that discipline members have appropriate license and clinical privileges and is responsible for discipline line peer review and for the quality and appropriateness of patient care provided by the activity therapy staff.

2.3.10 Director of Occupational Therapy Services: Serves as the chief occupational therapy consultant and provides leadership in the development and direction of the Occupational Therapy Services Programs. Ensures that discipline members have appropriate license and clinical Utah privileges and is responsible for discipline line peer review and for the

quality and appropriateness of patient care provided by the occupational therapy staff.

2.3.11 Director of Vocational Rehabilitation: Responsible for vocational rehabilitation programs throughout the hospital. Coordinates the patient industrial programs and provides assistance in discharge planning regarding vocational and employment issues. Responsible for the quality and appropriateness, professional standards, coordination, and delivery of vocational rehabilitation services.

2.3.12 Director of Quality Resources: Coordinates the Quality Improvement and Organizational Performance issues of the hospital under the direction of the executive staff. Supervises the Utilization Review process and Outcome Measure Projects.

3. Service Areas. Each service area is managed by a service area management team. The team consists of the Unit Administrative Director, the Unit Nursing Director, and the Unit Psychiatrist. These three individuals work together to assess, plan, implement, and evaluate the patient care services of their respective units. They meet weekly to coordinate service area patient program needs; personnel issues; budget; service area process improvement activities; service area educational needs; etc. Minutes from these meetings are sent to the Assistant Clinical Director for communication of SMT activities and to receive Executive Staff feedback.

3.1 Description: The hospital has patient treatment programs to meet the needs of a diverse population. Those areas include: Adult Services units for civilly committed patients, called Northeast, Northwest, Southeast, and Southwest; Forensic Services; Pediatric Services (Children's and Youth); Geriatric Services; and Life Habilitation Services. Each service area has its own detailed description of its clinical operation. These individual plans for services are included in their respective unit guidelines.

3.2 Acute Treatment Unit: The hospital operates a five bed acute psychiatric inpatient unit. This unit serves the acute needs of rural community mental health centers under contractual agreement.

3.3 Table of Organization:

4. Administrative Support Management Staff

4.1 Description: The administrative support management staff consists of those positions who supervise functions related to the administrative, maintenance, and physical support functions of the hospital. These positions report to the Assistant Superintendent who reports to the Hospital Superintendent.

4.2 Table of Organization:

4.3 Position Descriptions:

4.3.1 Assistant Superintendent: See 1.3.3.

4.3.2 Director of Human Resources: Responsible for coordinating and

presenting all training for staff including new employee orientation and continuing education. Coordinates the use of media technology, equipment, and materials for instructional and teaching programs at the hospital. Assures that DHRMOD rules and regulations regarding employee hiring, firing, and disciplinary actions are carried out appropriately. Liaison with community services such as Job Service, local schools, *etc.*

4.3.3 Director of Support Services: Responsible, as Director of Food Services, to formulate, with registered dietitians, program policies in nutrition services, assure that patients receive diet counseling, establish food service standards, conduct nutritional analysis, and formulate specifications for food and food supplies. Provide a food service program which meets the nutritional, psychological, cultural, and aesthetic needs of the patients. Manages, administers, and directs Housekeeping, Linen, and Laundry Services.

4.3.4 Director of Facility Management: Manages, administers, and directs the Maintenance personnel, which includes building maintenance, utilities, and mechanical systems maintenance, central heating plant, ground, and vehicle maintenance.

4.3.5 Director of Hospital Security: Responsible to assist the clinical staff in the control of combative, resistive and/or uncooperative patients; to apprehend and return walkaway patients; to respond to emergency situations on hospital grounds involving patients, staff, and/or visitors; to provide physical security for personnel, buildings, and state and personal properties; to implement and enforce traffic control on grounds; and to investigate criminal offenses, accidents, and other law violations. Implements the hospital's emergency preparedness plans through the Life Safety Committee. Coordinates with Public Safety Office personnel. Liaison to the State Department of Risk Management.

4.3.6 Fiscal Services Manager: Plans and coordinates the various functions of the Business Office, including General Accounting, Cost Accounting, Patient Accounts, Purchasing, Warehouse and Supply, Budgeting, Collections, and Fixed Assets. Supervises the hospital switchboard personnel.

4.3.7 Director of Computer Information Systems: Supervises and manages the Computer Information Systems Department. Ensures that the computer-based management information system is secure as well as accessible by approved hospital employees. Acts as liaison between the Utah State Hospital and Department of Human Services and the State Electronic Data Processing Department.

4.3.8 Legal Services Manager: Responsible for researching and developing policies and procedures that comply with state and federal laws and accrediting agencies. Liaison to the Attorney General and District Courts. Assist in the developing and implementing of new programs. Directly supervises the Legal Services Technician and Hospital Patient Advocate.

4.3.9 Director of Risk Management: Responsible for assessing, investigating, reporting, and monitoring risk management issues at the

hospital in the areas of life safety, security, personnel, and clinical risk management.

4.3.10 Chaplain: Responsible for the implementation, supervision, and administration of pastoral services and the provision of religious consultation and education.

4.3.11 Director of Volunteer Services: Coordinates the volunteer program. Supervises the recruitment, orientation, assignment, training, and program affairs for volunteers throughout the hospital. Also supervises the patient library and staff.

4.3.12 Medical Records Manager: Responsible for maintaining and providing health record information to those authorized to use it. Directly supervises the medical transcriptionists. Safeguards patient information from unauthorized access or use. Manages all medical record forms. Liaison to the State Archives. Responsible to classify all hospital records.

5. Administrative Management Staff.

5.1 Description: The administrative management staff consists of those individuals who supervise functions related to the support of patients and of treatment programs in an effort to provide quality care and programming. These positions report to the Assistant Clinical Director, who reports directly to the Hospital Clinical Director.

5.2 Table of Organization:

5.3 Positions Descriptions:

5.3.1 Admissions Director: Responsible for providing a centralized informational, referral, screening, and admission service for the adult general psychiatric treatment units. Included in this function is a liaison responsibility with other agencies who refer patients for admission to Utah State Hospital. Assists with unusual or extraordinary discharge problems as liaison with the Continuity of Care Committee.

5.3.2 Nursing Administrator: See 2.3.6 above.

5.3.3 Nursing Administrator of Education: See 2.3.6.3 above.

5.3.4 Unit Administrative Directors: Responsible for the supervision and management of unit business which includes, but is not limited to: interdisciplinary team leaders, development of unit programs, budget management, unit environment, policy and procedure, continuous quality improvement and personnel management.

5.3.5 Patient Education Services Director: Responsible for providing education services to children and adolescents ages 5 - 21. Programs provided meet the minimum acceptable education standards set for public schools by State and Federal rules, regulations, and statutes. Liaison to the State Office of Education.

Hospital Evaluation and Planning

Planning and evaluation are documented in an annual process. The hospital administrative staff meet to accomplish this purpose and to assign staff responsibilities. When preliminary work is completed, there is opportunity for further review and adjustment of the plan. Hospital-wide goals and objectives are shared with the treatment units, departments, and services within the hospital.

Reviewed: 8-92

Revised: 9-95

Revised: 12-98

Revised: 5-99

Revised: 3-02

Chapter: ⁱⁱ Plan for Services (PN)

Section 2: Responsibilities of DepartmentService Directors

Policy

Utah State Hospital provides effective leadership in each departmentservice of the facility. Departmentservice directors have functional responsibility and authority for the professional practice of members of their departmentservice. This authority is delegated to the departmentservice director by the Hospital Superintendent through the Hospital Clinical DirectorAssistant Superintendent.

Procedure

Departmentservice directors are responsible for:

1. The integration of the departmentservice into the primary functions of the organization.
2. The coordination and integration of interdepartmental and intradepartmental services.
3. The development and implementation of policies and procedures that guide and support the provisions of services.
 - 3.1 Policies and procedures are in compliance with hospital-wide policy and procedure.
4. Departmentservice directors screen the qualifications of applicants prior to the hiring interview process.
 - 4.1 The hiring of hospital staff involves the consensus of the departmentservice director, the departmentservice administrative director, and others as appropriate.
5. Determination of the qualifications and competence of departmentservice personnel.
6. The continuous assessment and improvement of the quality of care and services provided.
7. The maintenance of quality control programs, as appropriate.
8. The orientation and continuing education of all persons in the departmentservice.
 - 8.1 Departmentservice directors are responsible to ensure new employees

attend New Employee Seminar.

8.2 Department service directors are responsible to ensure that employees attend hospital mandatory inservice training.

8.3 Department service directors or designee have weekly contact with new staff members for the first month of the probationary period, then a minimum of monthly contact throughout the remainder of the probationary period.

9. Unit assignment of department service members.

10. Provide consultation to hospital personnel treatment units.

11. Staff member performance plans.

11.1 The clinical scope of work assignments of the staff members is the responsibility of the department service director in consultation with the unit clinical director and the unit administrative director.

11.2 Performance plans are developed by the department service director in consultation with the unit service administrative director and others as deemed appropriate.

11.3 Performance plans are reviewed annually and revised as necessary.

12. Provide clinical supervision of department service members.

12.1 Clinical supervision may be provided by a senior department service member with appropriate credentials and license.

13. Provide supervision for students and interns.

13.1 Department service directors have regular contact with students and interns, orients them as to expectations of performance, and provides consultation as needed.

14. Provide clinical supervision of status staff members.

14.1 Clinical supervision of status staff members includes:

14.1.1 Ongoing consultation.

14.1.2 Case presentations.

14.1.3 Inservice CME hours attended.

14.1.4 Weekly contact as appropriate for employees on corrective action plans.

15. Assist in the development of corrective action plans as needed in conjunction with the Administrative Director.

15.1 Corrective action plans are implemented upon review of the Director of Human Resources.

16. Recommendations for space and other resources needed by the department service.

17. Recommendations to hospital authority off-site sources for needed services not provided by the department service or the organization.

- 18. Provide clinical supervision of new staff members.
 - 18.1 Clinical supervision of new staff members includes:
 - 18.1.1 Ongoing consultation.
 - 18.1.2 Self-report from the new staff member.
 - 18.1.3 Review of clinical outcomes.
 - 18.1.3.1 Case presentation.
 - 18.1.3.2 Review of documentation.
 - 18.1.3.3 Therapeutic interventions.

*Initiated: 3-93
Reviewed: 9-95
Reviewed: 9-97
Revised: 3-02*

Chapter: ⁱⁱⁱ Plan for Services (PN)

Section 3: On Call Procedures

Policy

Utah State Hospital has an on call procedure to ensure 24 hour physician administrator services.

Procedure

1. Hospital personnel call the switchboard to request the on call physician or administrator be contacted.
 - 1.1 If an emergency, the switchboard will contact available personnel for immediate response.
2. The switchboard pages or calls the on call physician and/or administrator.
 - 2.1 On call personnel are called at home first and then paged.
3. If the on call personnel do not respond within **10 minutes**, the switchboard pages and/or calls them again using every reasonable means such as home phone, pager, and cellular phone.
4. If no response is received within twenty minutes, the switchboard will contact other personnel.
 - 4.1 If an on call administrator cannot be reached after two attempts, the switchboard will contact other personnel.

*Initiated: 12-93
Reviewed: 9-95
Reviewed: 8-97
Revised: 1-02*

Chapter: ⁱⁱⁱ Quality

Assessment and Improvement (QI)

Section 1: Quality Assessment and Improvement Standards

Policy

Utah State Hospital Governing Body; Superintendent; Hospital Clinical Director; Assistant Superintendent; Program Administrator; Medical Staff; unit, department, and service directors; and supervising nurses set expectations, develop plans, and implement procedures to assess and improve the quality of the organization's governance, management, clinical, and support processes.

Procedure

1. The leaders undertake education concerning the approach and methods of continuous quality improvement.
 - 1.1 The activities are planned in a collaborative and interdisciplinary manner.
2. The leaders set priorities for organization-wide quality improvement activities that are designed to improve patient outcomes.
 - 2.1 Performance expectations are established for new and modified processes.
3. The leaders allocate adequate resources for assessment and improvement of the organization's governance, managerial, clinical, and support processes, through:
 - 3.1 the assignment of personnel, as needed, to participate in quality improvement activities;
 - 3.1.1 Utah State Hospital organization collects data to monitor the performance of processes that involve risk or may result in sentinel event.
 - 3.2 the provision of adequate time for personnel to participate in quality improvement facilities; and
 - 3.3 information systems and appropriate data management processes to facilitate the collection, management, and analysis of data needed for quality improvement.
4. The leaders assure that organization staff are trained in assessing and improving the processes that contribute to improved patient outcomes.
5. The leaders individually and jointly develop and participate in mechanisms to foster communication among individuals and among components of the organization,

and to coordinate internal activities.

6. The leaders analyze and evaluate the effectiveness of their contributions to improving quality.

7. Utah State Hospital has a written plan for assessing and improving quality that describes the objectives, organization, scope, and mechanisms for overseeing the effectiveness of monitoring, evaluation, and improvement activities.

7.1 The following medical staff quality assessment and improvement activities are performed:

7.1.1 the assessment and improvement of the quality of patient care and the clinical performance of individuals with clinical privileges through:

7.1.1.1 participation by members of each department's service in intra- and/or interdepartmental service monitoring and evaluation of care; periodic review of the care; and communication of findings, conclusions, recommendations, and actions to members of the department's service;

7.1.1.2 the medical record review function;

7.1.1.3 evaluation and improvement in the use of the medications;

7.1.1.4 the pharmacy and therapeutics function.

7.2 The quality of patient care, including that provided by specific age groups, in all patient care services is monitored and evaluated.

7.2.1 The department's services in which care is monitored and evaluated include those on the Continuing Quality Improvement Organization Chart (See CQI Plan Appendix A).

7.2.2 The director of each department's service is responsible for including the department's service's activities in the monitoring and evaluation process. The department's service participates in:

7.2.2.1 the identification of important aspects of care relevant to the department's service;

7.2.2.2 the identification of indicators used to monitor the quality of the important aspects of care; and

7.2.2.3 the evaluation of the quality of care.

7.2.3 When Utah State Hospital provides a patient care service for which there is no designated department's service, the organization's leaders assign the responsibility for implementing a monitoring and evaluation process. (Example: speech, language and hearing, Medical Ancillary Services.)

7.2.4 When Utah State Hospital, in its care of patients, requires the services of another off-site health care organization, the monitoring and evaluation process examines the appropriateness of Utah State Hospital's use of the services and the degree to which the services aid in its care of patients. (Example: services provided by UVRMC, private community physicians.)

7.3 The following hospital-wide quality assessment and improvement activities are performed:

7.3.1 infection control;

7.3.2 utilization review; and

7.3.3 life safety review of accidents, injuries, patient safety, and safety hazards.

7.4 Relevant results from the quality assessment activities are used primarily to study and improve processes that affect patient care outcomes; and when relevant to the performance of an individual, are used as a component of the evaluation of individual capabilities.

8. There is a planned, systematic, and ongoing process for monitoring, evaluating, and improving the quality of care and of key governance, managerial, and support activities.

8.1 Those aspects of care that are most important to the health and safety of the patients served are identified.

8.1.1 These important aspects of care are those that; occur frequently or affect large numbers of patients; place patients at risk of serious consequences or of deprivation of substantial benefit when:

8.1.1.1 the care is not provided correctly; or

8.1.1.2 the care is not provided when indicated; or

8.1.1.3 the care is not provided when not indicated; and/or tend to produce problems for patients or staff.

8.2 Indicators are identified to monitor the quality of important aspects of care.

8.2.1 The indicators are related to the quality of care and may include clinical criteria (sometimes called "clinical standards," "practice guidelines," or "practice parameters.") These indicators are objective, measurable, and based on current knowledge and clinical experience.

8.2.2 Data is collected for each indicator. The frequency of data collection for each indicator and the sampling of events or activities are related to the frequency of the event or activity monitored, the significance of the event or activity monitored, and the extent to which the important aspect of care monitored by the indicator has been demonstrated to be problem-free.

8.2.3 The data collected for each indicator is organized so that situations in which an evaluation of the quality of care is indicated are readily identified. Such evaluations are prompted at a minimum by:

8.2.3.1 important single clinical events; or

8.2.3.2 levels or patternstrends in care or outcomes that are at significant variance with predetermined levels and/or patternstrends in care or outcomes.

Note: Such evaluations may also be initiated by comparison of the

hospital's performance with other organizations ("bench marking"). Such evaluations may also be initiated when there is a desire to improve overall performance.

8.3 When initiated, the evaluation of an important aspect of care:

8.3.1 includes a more detailed analysis of patternstrends in the data collected on the indicators;

8.3.2 is designed to identify opportunities to improve, or problems in, the quality; and

8.3.3 includes review by peers when analysis of the care provided by an individual practitioners is undertaken.

8.4 When an important opportunity to improve, or a problem in, the quality of care is identified:

8.4.1 action is taken to improve the care or to correct the problem; and

8.4.2 the effectiveness of the action taken is assessed through continued monitoring of care.

8.5 The findings, conclusions, recommendations, actions taken, and results of the action taken are documented and reported through established channels.

9. Each of the quality and assessment and improvement activities are performed appropriately and effectively.

9.1 Necessary information is communicated among departmentsservices andor professional disciplines when opportunities to improve patient care or problems involve more than one departmentservice andor professional discipline.

9.2 Information from departmentsservices and the findings of discrete quality assessment and improvement activities is used to detect trends, patterns, opportunities to improve, or potential problems that affect more than one departmentservice andor professional discipline.

9.3 There are operational linkages between the risk management functions related to the clinical aspects of patient care and safety and quality assessment and improvement function.

9.3.1 Existing information from risk management activities that may be useful in identifying opportunities to improve the quality of patient care andor resolve clinical problems are accessible to the quality assessment and improvement function.

9.4 The status of identified opportunities or problems is tracked to assure improvement or resolution.

9.5 The objectives, scope, organization, and effectiveness of the activities to assess and improve quality are at evaluated annually and revised as necessary.

Implemented: 4-92

Reviewed: 1-95

Reviewed: 6-98

Revised: 3-02

Chapter: ^{liv} Quality

Assessment and Improvement (QI)

Section 2: Quality Improvement Plan

Authority

Utah State Hospital is a psychiatric facility, mandated, established and funded by the State of Utah. The Governing Body, through the Superintendent/CEO of Utah State Hospital, requires and authorizes the establishment of an effective hospital-wide program to improve organizational performance. The Governing Body authorizes the Quality Improvement Council (QI Council) to provide overall direction and support for quality improvement in the hospital, and to approve the USH Quality Improvement (QI) Plan.

Purpose

The Quality Improvement Plan is designed to integrate hospital-wide activities to improve organizational performance at Utah State Hospital, with a particular focus on performance - what is done (efficacy, appropriateness) and how well it is done (availability, timeliness, effectiveness, continuity, safety, efficiency, respect and caring).

Utah State Hospital, as part of the Utah State Department of Human Services, and the Utah State Division of Substance Abuse and Mental Health, participates in the Department's Quality Improvement Process program. This program focuses on using quality management principles to improve the Department system-wide services to the people of Utah. The USH Quality Improvement plan, functions as part of the Department's quality management program.

Mission:

The mission of Utah State Hospital is to provide excellent in-patient psychiatric care.

Goals:

USH goals are to improve organizational performance focusing on:

1. Outcome Measurement
2. Training and Education
3. Professionalism and Culture
4. Relationships with Customers

Each service area will also develop goals for their service area which will be monitored quarterly along with the USH goals.

Objectives:

The USH Executive Staff hospital-wide objectives corresponding to the hospital-wide goals, are based on the Functional Chapters of the current Joint Commission for Accreditation of Healthcare Organizations and the Accreditation Manual for Hospitals.

Each service develops objectives corresponding to the hospital-wide and service area goals to improve organizational performance. The QI Council coordinates and integrates hospital-wide goals and objectives.

Scope of Program:

The scope of the QI Program includes both clinical and administrative services.

1. The Medical Staff

Psychiatry

Medicine

RNP

(Functions: Clinical Peer Review, CME, Medication Usage, Pharmacy and Therapeutics, Medical Records, Representation on Hospital-Wide Committees, and Shared and Service Specific Objectives)

2. Professional Staff

Nursing Service (RN, LPN, PT).

Social Work Services (CSW, MSW, SSA).

Psychology Services (PhD).

Therapeutic Recreation Service (MTRS, TRS, TRT)

Occupational Therapy Services (OTR).

Education Services

Vocational Rehabilitation.

(Functions: Clinical Peer Review, Representation on Hospital-Wide Committees, Shared and Service Specific Objectives)

3. Ancillary Medical Services

CentralSterile Supply

Dietary

Dental

Infection Control

Neurology

Optometry

Pharmacy

Physical Therapy

Podiatry

Radiology

Speech, Language, Hearing.

(Functions: Shared and Service Specific Objectives)

4. **Administrative Services**

Information Services

Facility Management

Fiscal Management

SafetyRisk Management

Human Resources

Security

Support Services

Volunteer Services

Adult Services: Northeast, Northwest, Southeast, Southwest, Life Habilitation

Forensic Services

Pediatric Services: Children's, Adolescent

Geriatric Services

(Functions: Shared and Service Specific Objectives)

5. **Hospital-Wide Committees**

Ethics

Infection Control

Environment of Care

Medical Records

Pharmacy and Therapeutics

Research

Suggestion

Utilization Review

Clinical RiskBehavior Management

6. **Other Sources** of QI Information include but are not limited to:

Reports from the Governing Body

Medical records

Risk Analysis (incidents, etc.)

Statements of Concern (patient, employee, and visitor)

Patient Surveys

Employee Surveys

Reports from Division of Substance Abuse and Mental Health

Reports from the Department of Human Services

Reports from the Joint Commission on Accreditation of Healthcare Organizations

HCFA Medicare Certification Report

HCFA State Inspection of Care Reports

ADT Office

IWC

Patient Advocate

Mental Health Centers

Volunteer Services

Education Services

Organization:

The Quality Improvement (QI) Council, the four Quality Improvement (QI) committees, and the hospital-wide committees have designated roles and responsibilities.

Responsibilities:

The Quality Improvement Council's responsibility is to provide overall direction and support for quality improvement through coordinating and integrating hospital-wide quality improvement functions. The Quality Resources staff facilitates the implementation of the QI Plan.

Quality Resources responsibilities:

1. Work closely with the Quality Improvement Council to coordinate and integrate all hospital-wide quality assessment and improvement activities and functions.
2. Provide the operational structure for the Quality Improvement Program.
3. Serve as quality improvement resources and liaisons to the Medical Executive Committee and other key hospital and Medical Staff committees.
4. Serve as manager of the Quality Improvement council and assist the Council through preparation of reports, referral of pertinent information and technical consultation, and
5. Serve as liaison between the hospital and the Western Psychiatric State Hospital Association and other external quality of care agencies.

Quality Improvement Council responsibilities:

1. Approve the annual hospital-wide Quality Improvement Plan, including goals and objectives consistent with overall hospital mission.

2. Assess hospital and service needs for quality improvement efforts through periodic review of:
 - Financial performance data
 - Direct requests from QI Committees and Service
 - QI Teams
 - Analysis and trends of customers complaints
 - Analysis and trends of patient, employee, family or visitor, or other surveys
3. Empower cross-functional teams, including:
 - Develop a charter
 - Select an appropriate team leader
 - Request appropriate team member assignments from administration
 - Assign a QI sponsor to each team from QI Council
 - Assign a facilitator for each team
 - Provide appropriate training for each team
4. Determine the need for training and education in quality improvement, including:
 - Service management training
 - Training to support the development and management of departmental quality improvement plans
 - Training on quality improvement tools and techniques
 - General employee training on quality improvement
 - Training incorporated into organizational and departmental orientation programs
 - Training for QI team leaders and facilitators
5. Provide general oversight and support for service quality improvement activities, including:
 - Assign a representative from the QI Council to each department for support
 - Review results of each Service's QI activities
 - Provide support materials and training as needed
 - Assure support, guidance, and training for mini-teams
6. Provide communications to services about quality improvement efforts and requirements.

Service responsibilities

Each service develops service objectives corresponding to hospital goals and objectives in the hospital-wide quality improvement plan. This plan guides a systematic, ongoing process for monitoring, evaluating and improving the quality and cost-effectiveness of the care or service provided. Requirements include:

- a. Every service participates in quality improvement activities.
- b. Every service management team supports service employees in quality improvement.
- c. Every service reports to their QI Committee on their activities and related quality improvement efforts quarterly.

Methodology:

The USH Methodology includes:

1. Assess selected process for improvement
2. Plan changes to improve the process
3. Implement the change
4. Evaluate the change

Risk Management:

Risk Management and safety management functions and information are essential elements of the Quality Improvement Program; the prevention, management and reduction of risk to patients, visitors and employees is one of the goals of the Quality Improvement Program. While quality improvement is concerned with the quality, adequacy and appropriateness of patient care and services and those processes which provide and support patient care, risksafety management is concerned with preventing or reducing those situations or occurrences which pose potential or actual harm or injury to patients, visitor or employees. Monitoring, evaluating, correction and reporting of safety occurrences and significant clinical events are performed through the Environment of Care Committee and reported to the QI Council.

ReportingCommunication of Findings:

Results of activities to improve organization performance are reported to Medical Executive Committee and the Governing Body. Copies of the minutes of QI Council are distributed to Medical Executive Committee, Governing Body, QI Committees, Hospital-Wide Committees and others as appropriate.

Confidentiality:

All patient care, medical, clinical, and administrative data and records of the QI program are confidential.

Evaluation:

On an annual basis, the Director of Quality Resources evaluates the objectives, scope, organization, and effectiveness of the hospital-wide Quality Improvement Program. The Medical Executive Committee and the Governing Body review the Annual Quality Improvement Report. Subsequent revisions to the QI Program are implemented by the QI staff.

Implemented: 5-25-89

Revised: 4-92

Revised: 12-6-94

Revised: 2-95

Revised: 12-98

Reviewed: 3-02

Chapter: ^{iv} Radiology Services (RS)

Section 1: Availability of Services

Policy

Diagnostic radiology services are regularly and conveniently available to meet the needs of patients as determined by the integrated medical staff.

Procedure

1. The Director of Radiology Services is a licensed radiologist who is a member of the integrated medical staff and has appropriate hospital-specific clinical privileges granted by the governing body.
2. A qualified registered radiology technologist is employed on a part-time basis. Radiology services needed at other times are provided through a contract with a service provider.
3. The hospital radiology technologist provides only general diagnostic x-rays.
4. Fluoroscopic and invasive procedures are done through a contract service provider.
5. The Director of Radiology and the Medical Services Administrator, with input from the radiology technologist, advise hospital administration as to space and equipment needs.
6. The Director of Radiology provides consultation to medical or clinical staff as requested.
7. The Radiology Department follows a comprehensive quality control program through the Utah State Department of Health, Bureau of Radiation Control.

The Radiology Department has a policy and procedure manual wherein safety rules and regulations are compiled.

8. On recommendation from the Radiology Department, a contract has been negotiated with a service provider to provide radiology services not provided by Utah State Hospital.
 - 8.1 A copy of the contract is in the radiology policy and procedure manual.
 - 8.2 The contract service provider is an accredited hospital which meets the same standards required of Utah State Hospital.
9. The Radiology Department has a comprehensive quality improvement program to

assure quality care. The contract service provider backup radiology service has a comprehensive quality improvement program.

Implemented: 4-6-89

Revised: 6-92

Revised: 2-95

Revised: 11-98

Reviewed: 6-01

Chapter: ^{lvi} Radiology Services (RS)

Section 2: Policies and Procedures

Policy

Policies and procedures have been developed which ensure effective management, safety, proper performance of equipment, effective communication, and quality control in the Diagnostic Radiology Services Department.

Procedure

1. Policies and procedures are developed with the cooperation of Nursing Services, medical staff, hospital administration, and other clinical services as required.
 - 1.1 The Utah Valley Regional Medical Center (UVRMC) Radiology Department, which provides radiology services to Utah State Hospital patients when these services are not available at Utah State Hospital, has a medical radiation physicist who can provide consultation and/or review policies and procedures.
 - 1.2 Policies and procedures are reviewed at least annually and more frequently as needed.

Each revision and/or review is documented.
2. Written policies and procedures include, but are not limited to, the following:
 - 2.1 All requests for radiological services are written by qualified individuals licensed to practice independently and authorized by Utah State Hospital clinical privileges to make such requests.
 - 2.2 Diagnostic radiology services may be provided at UVRMC through the current medical services contract.
 - 2.3 There are written policies and procedures to ensure competent care for emergency services or for patients who are seriously ill.
 - 2.4 Repairs and upkeep are contracted through an appropriate agency. Checks are performed at least annually and at the request of the radiology technologist, the Director of Radiology, and the Director of Medical Services.
 - 2.5 Monitor badges are sent quarterly to a health physics service for monitoring radiation levels of exposure on the radiology technologist.
 - 2.6 Radiographic equipment is certified every two years by the Bureau of Radiation control as meeting established criteria. Negative determinations by the Bureau are addressed as indicated.

Implemented: 4-6-89

Revised: 6-92

Reviewed: 2-95

Reviewed: 6-98

Revised: 7-01

Chapter: ^{lvii} Radiology

Services (RS)

Section 3: Consultation Reports

Policy

Consultation reports of diagnostic radiological studies are included in the patient's medical record.

Procedure

1. The requisition of diagnostic x-ray includes adequate information to aid in the performance of the procedure requested.
2. Interpretation of diagnostic studies is done by a radiologist with current clinical privileges at Utah State Hospital.
3. Authenticated reports are placed in the patient's medical record. A copy is retained in the Radiology Department.

Implemented: 4-7-89

Reviewed: 6-92

Reviewed: 2-95

Reviewed: 6-98

Reviewed: 6-01

Chapter: ^{lviii} Rehabilitation Services (RH)

Section 1: Rehabilitation Services

Policy

The Utah State Hospital is an inpatient psychiatric facility with separate treatment units. Each unit has its own team representative of each professional discipline and support staff. Rehabilitation services are provided on the various units by the appropriate staff assigned to particular service.

All units have recreational therapists who, with others, organize and provide the activity, recreation, and social events for the patients. Social work and psychology services and therapy are provided by the staff working on each treatment unit for those specific patients.

The Provo City School District has hired administrators and teachers to provide an educational program at the Utah State Hospital. Teachers have specific placement on the Children and Adolescent units, and provide a daily educational program. There is also provided, during afternoon and evening hours, adult education for all adult treatment unit patients. Referral is made for those patients who would profit from continuing education programs.

Speech and hearing evaluations are completed for children and youth by the nurse practitioners working on those units. This is completed at the time of admission. These evaluations for the adult units are done as part of the physical examination for each patient admitted to the Hospital, and is also completed by the nurse practitioners serving the needs of the units.

Physical Therapy is organized as a centralized service, and patients are referred by units as needed for assessment and service. Vocational Rehabilitation is also a centralized service, but very limited in what is offered due to there only being one staff member currently employed at the State Hospital with training in this area. Occupational Therapy is provided.

Specific policy and procedure for each of the rehabilitation services identified is documented in the Utah State Hospital Policy and Procedure Manual.

Implemented: 7-11-89

Reviewed: 1-91

Reviewed: 9-92

Revised: 4-95

Revised: 6-98

Chapter: ^{lix} Rehabilitation Services (RH)

Section 2: Availability and Delivery of Rehabilitation Services

Policy

Physical rehabilitation services are available, are based on the assessment of patient needs, are provided by competent professionals, and are delivered in accordance with a written plan for treatment.

Procedure

1. Each rehabilitation service (recreation therapy, social work, psychology, vocational rehabilitation, occupational therapy, speech and hearing, and education) has a description of their scope of service as part of their Utah State Hospital Operational Policy and Procedure (USHOPP) chapter as well as part of their quality assurance plan.
2. Each of the above rehabilitation services is provided by a qualified individual. These individuals meet appropriate requirements of education, training, and experience, and adhere to appropriate standards of care and treatment. Each individual providing rehabilitation services meets licensure, certification, or registration requirements as required by their discipline.
3. Rehabilitation services on each of the eight treatment units are under the direction of the unit clinical director who is a physician. Patients who receive physical rehabilitation services as part of a centralized program are referred by the treatment units under the direction and supervision of the unit clinical director.
4. When rehabilitation services are provided as either part of the treatment unit or by referral to a centralized service, there is appropriate documentation in the patient's individual comprehensive treatment program.
5. There are policies and procedures available in the USHOPP manual under each of the rehabilitation services provided that describe administrative responsibility, delivery of patient care, and the supervision of services.
6. Sufficient space, equipment, and facilities are available in each of the identified rehabilitation services provided at the hospital to support the clinical, educational, and administrative functions of the rehabilitation services provided. Specific details can be found in each of the specific chapters of the USHOPP Manual.
7. Staff involved in the delivery of rehabilitation services are appropriately oriented

with ongoing inservice training and appropriate continuing education as needed.

8. On referral for rehabilitation services, an assessment and evaluation are performed by a qualified professional to determine patient need.

9. The patient's treatment plan is based on the appropriate assessment and evaluation of the patient, with documentation in the treatment plan of the physical rehabilitation service prescribed. The patient and family as appropriate participate in the development and implementation of the treatment plan.

10. As rehabilitation services are provided, measurable goals are established for the patient in their treatment plan, including time-frames for achievement. The patient's progress and the results of treatment are assessed on a timely basis and documented in the patient's record.

11. The patient's medical record should appropriately document the need for physical rehabilitation services or the reason for referral. There should be a summary of the patient's clinical condition, with strengths and limitations identified. The goals of treatment and progress reports on a timely basis are appropriately charted, and a discharge summary that includes recommendations for further care is required.

Implemented: 7-11-89

Revised: 8-14-90

Reviewed: 9-92

Revised: 5-95

Revised: 6-98

Chapter: ^{1x} Rehabilitation Services (RH)

Section 3: Occupational Therapy Services

Policy

Occupational therapy is provided to patients through the hospital as appropriate.

Definitions

1. OT--Occupational therapy.
2. COTAL--Licensed occupational therapy assistant.
3. OTRL--Licensed registered occupational therapist.
4. OTS--Occupational therapy student.
5. OTA--Occupational therapy assistant student.

Procedure

1. OT services are provided when ordered by the attending physician.
 - 1.1 Evaluation for OT services are completed within three weeks of being ordered.
2. OT services are formulated after assessment of, and according to, the patient's needs, interests, life experiences, capacities, and deficiencies.
3. The objectives of occupation therapy (OT) are to:
 - 3.1 Provide meaningful activities which remediate to areas in which the patient's functioning is impaired;
 - 3.2 Provide treatment opportunities for functional performance to promote patient interaction, maximize independence, prevent further disability, and maintain health;
 - 3.3 Provide goal-oriented groups and activities to improve activities of daily living and aid in the development of adaptive skills.
4. Occupational therapy (OT) services include, but are not limited to:
 - 4.1 The assessment and treatment of occupational performance, including:

- 4.1.1 Independent living skills;
 - 4.1.2 Prevocational work skills;
 - 4.1.3 Playleisure abilities;
 - 4.1.4 Social skills;
 - 4.1.5 Cognitive skills; and
 - 4.1.6 Sensoryperceptual skills.
- 4.2 Therapeutic interventions, adaptations, and preventions.
- 4.3 Individualized evaluations of past and current performance.
 - 4.3.1 Evaluations are based on observations of individual and group tasks, standardized tests, record review, interviews, and activity histories.
- 5. Treatment goals are achieved through the use of selected modalities and techniques that may include, but are not limited to:
 - 5.1 Task-oriented activities, including practice of work, self-care, leisure, and social skills as well as the use of creative media, games, computers, and other equipment;
 - 5.2 Prevocational activities;
 - 5.3 Sensorimotor activities;
 - 5.4 Patientfamily education and counseling;
 - 5.5 Adaptation of the physical and social environment and the use of a therapeutic milieu;
- 6. Occupational therapy assessments and services are provided by qualified professionals.
 - 6.1 The occupational therapy staff include a licensed registered occupational therapist (OTR), licensed certified occupational therapy assistants (COTA), occupational therapy students (OTS), occupational therapy assistant students (OTA).
 - 6.2 OT staff attend hospital Inservices and off campus training as appropriate to ensure competence in handling medical and psychiatric emergency situations and to ensure quality care.
 - 6.3 OT staff provide Inservices regarding current practices, philosophies, and treatment modalities in occupational therapy.
 - 6.4 OT staff have input into clinical staffings, planning meetings, and service area meetings as appropriate.
 - 6.5 OT staff meet as needed or at least monthly to review programming, scheduling, and other administrative issues, as well as clinical matters, in-servicing, and training.
 - 6.6 Students, new employees, and volunteers are given an initial training period with ongoing training as needed.

7. Suitable and appropriate space, equipment, and facilities for OT services are provided to meet the needs of the patients.
 - 7.1 Suitable and appropriate space, equipment, and facilities are designated, constructed, and/or modified to permit all activity services to be provided, to the fullest extent possible, in pleasant and functional surroundings, and to be accessible to all patients, regardless of their disabilities.
 - 7.2 There is adequate and accessible space for offices, storage, and supplies, suitable to the age group the program serves.
 - 7.3 Space, equipment, and facilities utilized both inside and outside the program meet federal, state, and local requirements for safety, fire prevention, health, and sanitation.
8. Utah State Hospital provides for the safe use of kilns.
 - 8.1 Only authorized Occupational Therapy (OT) and/or Recreational Therapy (RT) staff operate kilns.
 - 8.1.1 Only authorized staff members open and unload a kiln after it has been fired.
 - 8.2 Patients are not allowed in areas where kilns are located without proper staff supervision.
 - 8.3 Exhaust fans are continuously in use when a kiln is in operation.
 - 8.4 Kilns are in compliance with hospital fire safety standards.
 - 8.4.1 Kilns are inspected on a yearly basis by the hospital Facility Management Department.
9. Kitchens being used for occupational therapy are properly staffed and supervised.
 - 9.1 Patients do not use kitchen facilities without staff supervision.
 - 9.2 All sharps and other potentially dangerous objects are kept in locked containers when not in use.
 - 9.2.1 Sharps are checked out and in by OT staff during each activity.
 - 9.2.2 Patients do not use sharps without staff supervision.
 - 9.3 All food items are stored in accordance with hospital standards.
10. Occupational Therapy areas are properly staffed and supervised.
 - 10.1 Patients do not use Occupational Therapy (OT) areas without staff supervision.
 - 10.2 All sharps and toxins are kept in locked containers when not in use.
 - 10.3 Materials are not taken from an OT area without authorization of OT staff.
 - 10.4 Flammable substances are stored in accordance with hospital fire safety regulations.

Reviewed: 9-92
Revised: 4-95
Revised: 11-98
Revised: 2-02

Chapter: ^{lxi} Rehabilitation Services (RH)

Section 4: Nursing Services

Policy

Nursing services focuses on the rehabilitation of the patient through the nursing process. This encompasses prevention of complications of physical disability, restoration to optimal function, and adaption to an altered life-style.

Procedure

1. When a patient is admitted, the nurse completes a nursing assessment that identifies problems, and initiates a nursing care plan focused on the identified problems.
2. Physical disabilities are identified on admission by the nursing assessment, and by the Nurse Practitioner's admission history and physical examination.
3. The nurse screens for immediate dietary, infection control, dental, and other physical needs and notifies the appropriate departments as indicated.
4. The registered nurse assists physical therapy, occupational therapy, recreational therapy, and other rehabilitative services through programming on the patient care unit in areas such as self-care skills, interpersonal relationships, sleep patterns, dietary needs, mild to moderate physical exercise, range of motion, use of prosthetic devices, and other rehabilitative treatments.
5. When a treatment procedure on the patient care unit is placed under the jurisdiction of the registered nurse, the appropriate service trains the registered nurse in the correct procedure for that treatment; *i.e.*, range of motion--physical therapy; use of splints--physical therapy.
6. Nursing rehabilitative services at the Utah State Hospital are limited. When comprehensive rehabilitative nursing services are required for a specific patient, the physicians refer the patient to a comprehensive rehabilitative service.
7. Patients who have a physical disability that requires rehabilitation, receive instruction in the areas of adaptive living skills, coping mechanisms, and health maintenance.
8. Discharge planning focuses on alternative living arrangements based upon specific needs.
9. The rehabilitative treatment of the patient remains a multi-disciplinary team approach.

10. Specific nursing care procedures are found in the policy and procedure manual under the specific title of the procedure.

Implemented: 12-88

Reviewed: 1-91

Reviewed: 9-92

Reviewed: 1-95

Revised: 6-98

Reviewed: 2-02

Chapter: ^{lxii} Rehabilitation Services (RH)

Section 5: Education Services

Policy

In cooperation with Provo City School District, Utah State Hospital provides educational services and programs to school-aged and adult patients. Educational services and programs provided meet the minimum acceptable education standards set for public schools by State and Federal rules, regulations, and statutes.

Definitions

1. Adult Patients are divided into two groups: 18 to 21 years old and over 21 years of age.
2. Basic Core Subjects include English, Mathematics, Science, Social Studies, and Reading.
3. Adult Education is offered daily, Monday through Friday.
4. East Wood is a secondary school for adolescents ages 12 to 18 years old.
5. IEP is an Individualized Education Program for those students who are classified as needing special education.
6. Mountain Brook is an elementary school for children ages 5 to 13 years old.
7. School-aged patients are 5 to 21 years old who do not have a valid high school diploma.
8. SEP is a Student Education Plan for those students who participate only in regular education.

Procedure

Child and Adolescent Services

1. There exists a Memorandum of Agreement between the Utah State Board of Education, the Division of Substance Abuse and Mental Health, and the Provo City School District which outlines each agency's responsibilities in serving school-aged patients at Utah State Hospital.
 - 1.1 The Memorandum of Agreement is reviewed at least bi-annually.
2. The elementary and secondary schools offer basic, state-approved curriculum

and instruction appropriate for the chronological ages and education needs of the students.

- 2.1 Low pupil-teacher ratios (8-10:1) are maintained for most academic subjects to capitalize on the individual strengths and to work on the deficiencies of the students.
3. Once a child or youth has completed the hospital admission orientation phase, his/her treatment coordinator refers the patient to the Director of Education to be officially enrolled in school.
 - 3.1 An assigned school staff member facilitates and supervises the education experiences (e.g. enrollment, assessment, placement, monitoring progress, etc.) of the student.
4. A written educational plan (SEP or IEP) is developed and followed for each patient.
5. Students enrolled in the secondary school may earn grades and credits which count towards their high school graduation.
 - 5.1 Written report cards are given out by the school on a quarterly basis.
6. Academic and behavioral progress of each student is monitored and documented in the student's official school record.
7. Daily meetings between school staff and clinical staff are held to coordinate educational activities with clinical programs.
8. An educational evaluation is completed every 90 days.
 - 8.1 The completed evaluation is made part of the student's school and medical records.
9. Both Mountain Brook and East Wood schools are able to provide supplementary educational services and classes to those students who qualify. These activities are conducted outside of the regular school times.
10. School representatives assist in discharge planning of students.
 - 10.1 The school staff assists with the student's enrollment in a new school setting.
 - 10.2 The student's official school records are forwarded to the educational personnel of the new school.

Vision and Hearing Screening Evaluations

11. Within thirty days following the admittance of a child or adolescent to the hospital, the Director of Education informs a designated registered nurse of the need for that student to receive a vision and hearing screening.
12. The school nurse screens each referred patient. If no deficiency is noted, a report form for hearing and vision screening results is completed by the nurse. A copy of this completed screening report is placed in the patient's medical and educational files. Any hearing and/or vision deficiencies are noted on this same report, and a more extensive follow-up examination is recommended by the nurse.

13. The cost of the initial screening for vision and hearing is covered by the public schools' budget. Any follow-up procedures and corrective appliance(s) needed by the patient are the responsibility of the hospital.

Adult Education Services

14. There exists a contract between the Provo City School District and the Utah State Hospital for adult educational services.

14.1 This contract is reviewed at least annually.

15. Adult patients are referred to the Adult Education Instructor for evaluation for adult educational services.

15.1 Referrals may be made any time after admission to USH.

15.2 An adult education employee interviews and tests each referred adult patient to assess levels of academic performance and anticipated benefits from further educational services.

15.2.1 Included in the interview process is the discussion and formulation of educational plans; collection of credits earned elsewhere; determination of credits needed to meet requirements for graduation; determination of current reading, writing, and mathematic skills, and formulation of goals for earning the credits needed and desired.

16. Upon completion of the interview and testing process, an individualized learning contract is established that includes the following:

16.1 outline of the books to be read;

16.2 school assignments to be completed;

16.3 papers to be written;

16.4 tests to be taken;

16.5 the days and times the adult student will attend the Center for Directed Studies; and

16.6 the credits which will be earned for completing the program.

17. If passing the GED is selected as an educational goal, a practice GED test will first be administered to determine student performance on an actual GED test.

17.1 If the results of the practice GED test indicate that additional educational services are needed, an individualized GED preparation course is developed.

17.1.1 Upon completion of the GED preparation course, another GED practice test will be administered.

17.2 Students who demonstrate a level of proficiency at the passing level are transported to an official designated testing center to take the GED exam.

18. Reports are generated and provided to the USH Administration on an annual basis. The reports include the following:

18.1 names of adult students served;

18.2 number of hours spent in the program;

18.3 age of students; and

18.4 the level of educational achievement.

Implemented: 6-10-88

Reviewed: 12-90

Revised: 4-92

Reviewed: 2-93

Reviewed: 9-95

Reviewed: 6-98

Revised: 3-02

Chapter: **lxiii Rehabilitation Services**

(RH)

Section 6: Physical Therapy Services

Policy

Physical therapy is provided to patients throughout the hospital as appropriate.

Procedure

1. The Utah State Hospital has a written plan describing the organization of physical therapy services, or arrangements for the provision of such services, to meet the needs of patients. The physical therapy service is to be provided by an adequate, qualified staff that receives competent medical direction.

1.1 The Department of Physical Therapy at the Utah State Hospital is a special care unit for treatment of various infectious, metabolic, traumatic, and physiological disorders including neurological, orthopedic, and general medical problems, all of which may be characterized by pain, tenderness, stiffness, edema, redness, decubiti, weakness, and/or paralysis.

1.2 Physical therapy services provide identification, prevention, remediation, and rehabilitation of acute or prolonged physical dysfunction or pain, with emphasis on movement dysfunction. Such therapy encompasses examination and analysis of patients and the therapeutic application of physical and chemical agents, exercise, and other procedures to maximize functional independence.

1.3 Physical therapy services include, but need not be limited to, the following:

1.3.1 An initial physical therapy evaluation and assessment of the patient prior to the provision of services;

1.3.2 The determination and development of treatment goals and plans in accordance with the diagnosis and prognosis, with a treatment program established to aim at preventing or reducing disability or pain and restoring lost function;

1.3.3 Progressive-active, active-assistive, active-resistive, and passive exercises, muscle testing, massage and tactile stimulation, cervical traction,

and gait training, including crutch walking, various tables, mats, weights, wall pulleys, shoulder wheels, parallel bars, floor ladder, postural tilt table, stairs, incline ramps, walkers (and other ambulation devices), exercise bicycles, a multi-use Universal exercise apparatus, Sprint Stair-Stepper, a Health Rider, a treadmill, and other exercise equipment.

1.3.4 Therapeutic interventions that focus on posture, locomotion, strength, endurance, cardiopulmonary function, balance, coordination, joint mobility, flexibility, pain, functional abilities in developing daily-living skills, agility, Kinesthetic and proprioceptive awareness, relaxation stress management, body awareness, directionality, and space-distance orientation, as well as to improve the psychological self-image of patients;

1.3.5 Postural positioning includes tilt-table positioning and Burger-Allen exercises to improve circulation and kidney function and to prepare patients for weight-bearing activities;

1.3.6 The application of modalities includes but is not limited to heat, cold, light, air, water, sound, electricity, massage, mobilization, bronchopulmonary hygiene, and therapeutic exercise with or without assistive devices;

1.3.7 Heat modalities include whirlpool, Hubbard Tank¹, contrast baths, infra-red lamps, microwave diathermy, hydrocollator packs and paraffin bath to improve circulation, increase joint range of motion, induce relaxation and to decrease stiffness, soreness, tenderness, pain, and edema;

1.3.8 Other modalities include ultra-sound and iontophoresis to improve circulation, increase joint range of motion, induce relaxation and to decrease stiffness, soreness, tenderness, pain and edema. Also included shall be ultra-violet (used to increase skin pigmentation and reduce secretion from sebaceous glands) and electrical muscle stimulation (used to diagnose pathological or physiological neuro-muscular disorders);

1.3.9 Assessment and training in locomotion, including, as appropriate, the use of orthotic, prosthetic, or assistive devices;

1.3.10 Patient and family education, as appropriate.

2. Physical therapy services staff monitor the extent to which services have met the therapeutic goals relative to the initial and all subsequent examinations, as well as the degree to which improvement occurs relative to the identified physical dysfunction or the degree to which pain associated with movement is reduced.

3. There is adequate space, equipment, and facilities to fulfill the professional, educational, and administrative needs of physical therapy services.

3.1 Physical therapy services are available to any patient needing such. Ramps are provided, both in front and back of the building, and there is an elevator from both the first and second floors of the Hyde Building. Adequate space is provided for physical therapy. The main room currently used is 49.5 x 39 or 1,930 square feet. Additional space is used in the Hyde Building "Little Theater". Windows along the north and west side of the room provide ample light and ventilation. There are two treatment rooms, 10 x 6, with an examining table in each, for

examination and treatment. There are separate bathroom facilities for men and women. The office currently being used is 10 x 10 with glass windows which provide full view of the treatment area. Office furniture consists of two desks, a bookcase, slots for retention of patient charts, and a filing cabinet where physical therapy records are kept.

3.2 Physical therapy services at the Utah State Hospital are staffed and organized to meet the particular needs of the hospital. All services are under the general direction of the Director of Medical Services. Periodic evaluation of all equipment, including electrical machines, is performed by electricians and mechanical shop personnel at one-year intervals to insure safe operation of all equipment. When such inspections reveal the need for equipment calibration, the indicated apparatus is returned to the manufacturers or submitted to local qualified technicians, if available. A log book is kept showing the date, time, and nature of inspections, repairs, and/or calibrations.

¹ Use of Hubbard Tank is arranged through contracted services.

4. Physical therapy treatment is initiated only upon the written prescription of the responsible physician, is under a written plan of care, and is regularly evaluated. The PT Department is notified (by phone or e-mail), stating the reason for the referral. A note is made on the medical order page, stating date and time of message to PT.

4.1 The PT department schedules, with the unit, the time for the PT assessment.

4.2 The Physical Therapy Assessment includes: patient profile; psychological diagnosis; past medical history; current medical status; patient preference goals assessment; problem baseline data; short-term goals; long-term goals; physical therapy treatment plan; instructions to patient; and recommendations to staff. The RPT completes the PT assessment which is dictated and copies placed in the consult section of the patient's chart and in the PT department files in the PT office. The PT assessment is typed by the medical records department and includes above.

4.3 The physician or nurse practitioner meets with the unit treatment team to incorporate PT into the Individual Comprehensive Treatment Plan (ICTP), which includes the reason for PT in the medical problem list. The registered physical therapist is the staff member responsible for physical therapy treatment programs. The patient's name is added to the PT schedule, which is updated weekly and copies sent to all units. If PT is not recommended by the RPT, the unit is notified and the PT order is withdrawn.

5. Documentation during course of therapy.

5.1 The physical therapy aide uses the Physical Therapy Treatment Record (formerly Physical Therapy Prescription) to record the frequency of visits and type of treatment given. The physical therapy treatment record is to be kept in the physical therapy office.

5.2 The physical therapy aide records the patient's progress on the gray progress note sheet on a monthly basis. The progress note reflects back to the baselines, goals, patient behaviors, etc. Weekly notes are required during the first eight weeks of admission, and for patients with changing diagnoses and/or treatment modalities. A progress note must be written for any unusual or significant problem or behaviors that occurs in the Physical Therapy Department, e.g., "Patient became dizzy after completing the walking exercises."

5.3 Progress notes are written in the gray progress notes by the registered physical therapist as stated in the ICTP. This note focuses on attendance, psychological behaviors of patient, treatment protocol, progress towards goals and other pertinent information.

6. Documentation requirements for missed appointments:

6.1 It is the responsibility of the unit nursing staff to notify (by phone or e-mail) the Physical Therapy Department if a patient is unable to keep a physical therapy appointment and to document in the progress notes that the appointment was missed and the reason why.

6.2 It is the responsibility of the Physical Therapy Department to notify the unit RN if the department is unable to meet the posted schedule.

7. Documentation of special incidents:
 - 7.1 The Physical Therapy Department staff documents incidents involving harm or potential harm to patients. The report (both copies) is returned to the unit with the chart. The Physical Therapy Department staff notifies the unit nursing staff by telephone as soon as possible after the incident occurs.
8. Other documentation requirements:
 - 8.1 Patient's chart goes with the patient to each physical therapy appointment.
 - 8.2 The physical therapy attendance record is documented daily.
9. In cases of inclement weather, arrangements are negotiated between the unit and the Physical Therapy Department staff to determine care that is in the best interest of the patient.
10. The physical therapy services staff consists of the Director of Medical Services, the Technical Director of Physical Therapy (RPT), the Physical Therapy Coordinator (RN), and physical therapy aides. The Technical Director of Physical Therapy (RPT) is responsible for the specific administration of the patient treatment program. Designated tasks are performed by the PT aides who perform services under the supervision of the Technical Director. The PT aides are seniors at Brigham Young University majoring in pre-physical therapy. On-the-job training include indoctrinations in the use of the following modalities: whirlpool; ultra-sound; microwave diathermy; iontophoresis, electrical muscle stimulation, cervical traction, hydrocollator packs, paraffin wax, infrared lamp, ultraviolet lamp, postural tilt table, gait training, therapeutic exercises (including the use of the Universal machine), assorted weights, bicycles, stair-stepper unit, Health Rider, treadmill, and the relaxationstress treatment program. The training program is of a continual nature with new methods being reviewed when needed. Inservice training sessions are held 8-10 times per year to update knowledge of PT aides.
11. The patient is encouraged to participate in the decision-making process relative to his/her treatment program. Where appropriate, family support and involvement are also encouraged. Discharge planning and follow-up care are a treatment team responsibility, and again, the patient and family are encouraged to participate. Where indicated, written instructions are provided by the RPT to the patient and family upon discharge.
12. Coordination of physical therapy services with other services is accomplished in the treatment team approach. Each of the disciplines is represented on the treatment team and is immediately available and responsible for counsel in the patient's behalf.
13. A written plan is established for referral of patients for evaluation and treatment for services not provided at the hospital. Referral of patients for evaluation and treatment, whose needs may not be met adequately through the use of established hospital treatment programs, is arranged by the unit physician after consultation with the Technical Director, the Physical Therapy Department, and such other hospital personnel as needed.
14. Coordination for prescription of all orthotics and prosthetics is done by the Registered Physical Therapist.

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Revised: 4-30-86
Revised: 5-13-88*

Revised: 6-1-89
Revised: 3-92
Revised: 2-93
Revised: 1-95
Revised: 11-98

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Section 7: Psychology Services

Policy

The Utah State Hospital has psychological services designed to enhance the patient's emotional and behavioral adaptation to the hospital, family, and community. An important part of this service is the assessment of key psychological deficits and the remaining personal strengths which offer a foundation for improved adjustment. A second part of the service is the timely provision of psychological interventions indicated by the patient's clinical condition.

Procedure

1. Psychological services include the following:
 - 1.1 Assessment of intellectual, cognitive, neuropsychological, vocational, and behavioral functional levels through use of standardized testing instruments, interviewing procedures, and background data.
 - 1.2 Provision of such treatment interventions as individual and group psychotherapy, family therapy, and consultation with family members and other professionals who are part of the therapeutic team or part of follow-up treatment agencies. Relaxation, behavioral treatment techniques, cognitive therapy, biofeedback, and various insight oriented therapies are examples of modalities that may be provided.
2. The psychology staff member is part of an ongoing process of monitoring patient progress and adaptation through the following:
 - 2.1 Periodic re-assessment through review of behavioral adjustment data, interviewing procedures, and additional psychological testing, where indicated.
 - 2.2 Active participation in clinical staffings on patients for whom a referral has been submitted or when the psychologist is the provider of a treatment modality.
 - 2.2.1 A written report or electronic note is submitted to the treatment coordinator and psychiatrist presenting the current assessment relevant to the treatment plan of the patient.
3. The above psychological services are provided upon written referral from unit clinical directors.

3.1 When such referrals are made on units without assigned psychological staff, they are channeled through the director of the psychology discipline. In such cases, written reports or electronic notes ordinarily take the place of attendance at clinical staffings.

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Chapter: ^{lxv} Rehabilitation Services (RH)

Section 8: Therapeutic Recreation Services

Policy

The Utah State Hospital provides therapeutic recreation services to meet the social, cultural, intellectual, physical, and emotional needs of its patients. Therapeutic recreation services are included in the therapeutic treatment program of each patient. Therapeutic recreation services include and involve a variety of treatment modalities which include but are not limited to social skills, physical skills, arts and crafts skills, outdoor skills, intellectual skills, and leisure education skills.

Procedure

1. The Utah State Hospital (USH) is organized into specialized treatment units with unique program emphasis, including Pediatric Services, Forensic Services, Speciality Services (Geriatric and Adult), and Adult Services. Special program emphasis requires Therapeutic Recreation Services to exercise considerable flexibility in order to meet particular needs of the individuals on the different units. A team of licensed therapeutic recreation specialists delivers a broad, comprehensive therapeutic recreation program. Therapeutic recreation specialists are assigned to specific treatment units. They coordinate their work with the unit treatment team and the unit patient government.
2. A Therapeutic Recreation Assessment is performed on the patient's leisure, social, and recreational abilities, deficiencies, interests, barriers, life experiences, needs, and potential. Recommended treatment plans are formulated from the information obtained through the assessment process. This process is completed within fourteen days from the time of admission to the hospital.
 - 2.1 Each patient is interviewed by a professional therapeutic recreation specialist to obtain the necessary information for the assessment. The patient is oriented to the available therapeutic recreation services during this interview.
 - 2.2 Information gathered from this assessment is recorded on the Therapeutic Recreation form and is placed in the patient's chart.
3. Therapeutic recreation services are designed to improve social, emotional, cognitive, and physical functional behaviors as necessary prerequisites to future leisure social involvement and proper integration into the community.

3.1 Therapeutic Recreation Services utilizes community resources on a regular basis. These community resources are scheduled and coordinated through the service area recreation therapists, occupational therapist, therapeutic recreation technicians, the Director of the Therapeutic Recreation Discipline, and the Public Relations Officer as appropriate.

3.2 Liaison is established with the larger community to utilize that resource. Community swimming pools, theaters, activity centers, bowling, golfing, miniature golf, roller skating, parks, zoos, horseback riding stables, parks, and restaurants are among those resources serving the patient programs. Education tours and field trips are taken to universities, factories, state agencies, and private businesses and industries. Cultural events are provided through civic agencies, university drama and art, private production companies, high school music and drama departments, etc. The patients participate in sporting events through the universities and communities. Every available resource in the community is considered for its value and availability to improve patient care and meet needs.

3.3 Volunteers and students provide an ongoing human resource to the patients. This effort is coordinated through the Director of Volunteer Services and the Director of the Therapeutic Recreation Discipline. A volunteer and student orientation packet is provided to each individual assigned to provide service to patients. Volunteers and students are evaluated on a regular basis.

4. Leisure education and leisure counseling designed to help the patient acquire the knowledge, skills, and attitudes needed for independent leisure social involvement, adjustment in the community, decision-making ability, and appropriate use of free time is offered by Therapeutic Recreation Services.

4.1 Leisure counseling is offered by the master therapeutic recreation specialists on a consulting basis as scheduled and as needed.

4.2 Leisure education is offered and performed by the master therapeutic recreation specialist and the therapeutic recreation specialist on a regular scheduled basis.

5. Therapeutic Recreation Services staff monitor the extent to which goals are achieved relative to the use of leisure time and the acquisition of socialization skills.

5.1 Each patient has an Individualized Comprehensive Treatment Plan (ICTP) that includes specific goals pertaining to the therapeutic recreation services provided for that patient. This treatment plan is reviewed and revised as necessary and in accordance with hospital standards and in conjunction with the unit clinical members.

5.2 Each patient's progress or lack of progress is noted every thirty days in regards to their goals found in the treatment plan. These notes are recorded in the progress notes (USH-61-0994) in the patient's chart.

5.3 Each therapeutic recreation activity is recorded on the Therapeutic Recreation Note form and is kept in a file by the unit therapeutic recreation specialist. This patient's attendance, participation, behavior, and interaction are noted on this form.

5.4 As part of USH's continuous quality improvement (CQI) program, the quality and appropriateness of patient care provided by Therapeutic Recreation Services

are monitored and evaluated, and identified problems are resolved.

5.5 The Director of Therapeutic Recreation Services is responsible for assuring that there is a planned and systematic process for the monitoring and evaluation of the quality and appropriateness of patient care and for resolving identified problems.

5.6 The quality and appropriateness of patient care are monitored and evaluated in all major clinical functions of Therapeutic Recreation Services. Such monitoring and evaluation are accomplished through the following means:

5.6.1 Routine collection by Therapeutic Recreation Services, or through the hospital CQI program, of information about important aspects of the therapeutic recreation services provided.

5.6.2 Periodic assessment by Therapeutic Recreation Services, or through the hospital CQI program in conjunction with Therapeutic Recreation Services, of the collected information in order to identify important problems in patient care or opportunities to improve care.

5.7 When important problems in patient care or opportunities to improve care are identified, actions are taken, and the effectiveness of the actions is evaluated.

6. The objectives of Therapeutic Recreation Services are as follows:

6.1 modify patient behavior by teaching social skills;

6.2 provide cultural, social, and physical activities to allow patients the opportunity to become aware of the appropriate facilities where they can use leisure time in a constructive way upon discharge from Utah State Hospital;

6.3 provide an opportunity for constructive expression through various activities;

6.4 help patients overcome dehumanizing elements of boredom and apathy;

6.5 promote the positive aspects of a patient's behavior by developing interpersonal skills;

6.6 develop more positive emotional experiences for patients;

6.7 provide activities that help to maintain and increase physical fitness;

6.8 provide activities that involve the entire treatment community so that staff members become more aware of patient problems and needs;

6.9 teach the patient how to relax and have fun; and

6.10 provide diversionary activities to enhance and facilitate the overall treatment process.

7. The objectives of Therapeutic Recreation Services are stated in each patient's ICTP. These objectives are related to two types of activities.

7.1 Diversionary activity consists of a program which serves as a distraction from the daily schedule or from the patient's disability. These programs have generalized goals of socialization, getting out of the environment, enjoyment, learning appropriate leisure skills, and/or getting the patient's mind off his/her problems or disabilities. These activities often help the patient achieve a positive

state of being so that other therapy can be done.

7.2 Prescribed therapeutic activity is highly goal-oriented, with the activity being a tool to bring about desired change in the individual. Individual objectives for prescribed therapeutic activity are written into the individual patient treatment plan. With this type of program, the activity, although important in and of itself, is secondary to meeting the goals and objectives.

8. Appropriate therapeutic recreation services are provided for all patients for daytime, evenings, weekends, and holidays in order to meet patients' needs. Activity schedules are posted where patients and staff have access to them.

8.1 Patients participate in the planning, organization, and implementation of the activities. Provision for this process is the responsibility of each unit therapeutic recreation specialist.

8.2 Each unit provides daily leisure time for the patients which may be used to fulfill their personal recreational interests and feelings of human dignity.

8.2.1 Space and equipment are provided for the patients on the dorms, *i.e.*, television, stereos, tape recorders, VCR's, etc.

8.2.2 Leisure-time supplies are available to the patient, including magazines, novels, box games, handicrafts, writing supplies, etc.

9. Appropriateness to leave the unit for recreational activities will be determined by the recreational therapist after clearing each patient for each activity with the unit charge nurse. The charge nurse has the responsibility to determine the patient has the necessary level to participate.

10. Vehicles used as common carriers of patients are labeled with the state insignia. No common carrier of patients is labeled in any way that may call unnecessary attention to the patients. Utah State Hospital provides transportation to meet the needs of the patients. A fleet of twelve vans, mobile kitchen, box van, and passenger cars provides vehicle transportation.

11. Utah State Hospital provides suitable and appropriate space, equipment, and facilities to meet the patients' needs. These facilities are provided on a hospital and unit basis.

11.1 Utah State Hospital provides the following on-campus outdoor space and facilities: softball diamond, fish pond, outdoor amphitheater, playground with obstacle course, outdoor basketball and volleyball, picnic area, open space, and multi-purpose indoor activity center that are pleasant and functional areas accessible to all patients, regardless of their disabilities.

11.1.1 The multi-purpose indoor activity center provides resources that include a therapeutic pool, gymnasium, theatrical stage, weight training and conditioning areas, canteen, dressing rooms, storage and equipment areas, office space, and reading and music libraries. Each hospital unit has access to craft and ceramic rooms and game areas. There is a little theater in the Hyde Building.

11.1.2 The hospital has on inventory a variety of equipment to meet patient activity needs. The equipment is centralized and is available to the various service areas.

11.1.2.1 Sporting equipment made available to the patients includes backpacking equipment, rubber rafts, ping-pong, electronic games, football, basketball, soccer, volleyball, tennis, badminton, horseshoes, beach balls, frisbees, tubes, ring toss, ropes, snow skis, snow shoes, etc.

11.1.2.2 Camping equipment made available to patients includes tents, poles, fishing equipment, sleeping bags, and coolers.

11.1.2.3 Art and craft supplies available to patients include ceramics, water colors, pastels, oils, embroidery, candle-making, knitting, leather crafts, pottery, macrame, decoupage, bead work, mosaics, needle crafts, wood shops, etc.

11.2 Special equipment and resources are provided to patients with altered life situations. Movies, parties, arts and crafts, and other activities are brought to the patient. Documentation of these provisions are noted in the progress notes in the patient's chart.

11.3 All recreational equipment rooms and activity areas and facilities, both inside and outside the hospital, meet the federal, state, and local requirements for safety, fire prevention, health, and sanitation.

12. Therapeutic Recreation Services are supervised by the Director of Therapeutic Recreation and assisted by qualified and licensed professional and para-professional staff sufficient in numbers and skills to meet the needs of the patients and to achieve common goals.

12.1 The Director of Therapeutic Recreation Services has a master degree or the equivalent in professional experience and is licensed as a master therapeutic recreation specialist.

12.2 The Director of Therapeutic Recreation Services is qualified in administrative procedures and has a proven knowledge of professional standards.

12.3 The Director of Therapeutic Recreation Services is responsible to the Hospital Clinical Director for the overall operation, performance, and quality of service rendered by Therapeutic Recreation Services.

13. Each patient service area therapy program is supervised by a qualified and licensed professional. The service area specialist is licensed as a master therapeutic recreation specialist or therapeutic recreation specialist.

13.1 The service area recreation specialist has a proven knowledge of professional standards and the competency to plan, implement, evaluate, and direct unit therapy programs.

13.2 The unit recreation specialist is assisted by competent and licensed para-professionals in planning, implementing, and evaluating the unit activity therapy programs. The unit para-professional is licensed as a therapeutic recreation technician.

14. Therapeutic Recreation Services provide ongoing staff development programs and encourage extramural studies, evaluation, and research regarding activity services.

15. Therapeutic Recreation Services staff are encouraged to attend a monthly

hospital-wide workshop presented by the Staff Development Department. The topics of these workshops deal with a variety of health-service-related subjects. A record of participation and attendance is kept in the Staff Development Department.

15.1 Therapeutic Recreation Services staff provide inservice training upon request. These inservice training sessions focus on a variety of activity-related topics.

15.2 Therapeutic Recreation Services staff are encouraged to attend workshops, conferences, and other profession-related seminars to receive training and instruction. Unit personnel are encouraged to belong to the various national and state professional organizations.

15.3 Therapeutic Recreation Services staff are encouraged to enroll in classes through the higher education institutions in areas of professional interest.

16. Therapeutic Recreation Services staff participate in clinical and administrative committees and conferences as assigned. The Director of Therapeutic Recreation Services directs the assignment of members of the discipline to hospital committees as requested and required.

17. Therapeutic Recreation Services staff receive training and demonstrate competence in handling medical and psychiatric emergency situations through regular service area, discipline, and hospital-wide Inservices. Documentation of participation and attendance is recorded in the inservice records of the service areas, the disciplines, and the hospital Staff Development Department.

18. Therapeutic Recreation Services staff are encouraged to produce one approved research project yearly. All proposed research is presented in advance to the hospital Research Committee for approval.

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Section 9: Vocational Rehabilitation Services

Policy

1. Vocational assessment is done on appropriate patients referred by the unit treatment team staff when deemed necessary and is used to help develop the individual comprehensive treatment plan (ICTP).
2. Patients identified by Utah State Hospital treatment units as benefiting from vocational counseling receive counseling on their specific vocational needs, such as their vocational strengths and weaknesses, the demands of their current and future jobs, the responsibilities of holding a job, and the problems related to vocational training, placement, and employment.
3. The Utah State Hospital units and staff refer appropriate patients to the Utah Division of Rehabilitation Services for vocational rehabilitation services. The Division of Rehabilitation Services assigns as many vocational rehabilitation counselors as necessary to give adequate service to Utah State Hospital patients. The Division of Rehabilitation Services agrees to follow all provisions and standards contained within the State Plan for Vocational Rehabilitation Services and the Federal Register.
4. As part of the rehabilitation process, the industrial therapy program of the Utah State Hospital provides jobs, job training, and on-the-job evaluation within the hospital setting. Work assignments are designed to provide therapeutic benefit to the patients and help them develop work habits and attitudes, self-confidence, skills in dealing with peers and supervisors, and other work skills necessary to succeed in further vocational training or jobs in the community as they leave the hospital setting. Vocational assessment is required on all patients referred for off ward industrials. Assessment is not required for on ward industrials because this is part of the pre-vocational evaluation process.

Procedure

1. When deemed necessary and referral is made by the unit treatment team, vocational assessment is done by hospital vocational rehabilitation staff. The patient's vocational needs are assessed with regard to the following:

- 1.1 work history;
- 1.2 educational background, including academic and vocational training;
- 1.3 amenability to vocational counseling;
- 1.4 current work skills and potential for improving skills or developing new ones;
- 1.5 work habits related to tardiness, absenteeism, dependability, honesty, and relations with co-workers and supervisors;
- 1.6 expectations regarding the personal, financial, and social benefits to be derived from working.
- 1.7 employability/trainability - aptitudes, interests, attitudes, and motivations for getting involved in future education, training, and employment;
- 1.8 skills and experiences in seeking jobs;
- 1.9 personal grooming and appearance;
- 1.10 physical and intellectual capacity;
- 1.11 emotional and social adjustment, prognosis, psychiatric supervision needed;
- 1.12 problems, strengths, disabilities, and limitations;
- 1.13 vocational treatment recommendations.

2. Patients identified by Utah State Hospital treatment units as benefiting from vocational counseling receive counseling on their specific vocational needs. Counseling is provided by Utah State Hospital Rehabilitation staff, the Division of Rehabilitation Services, other community vocational resources.

2.1 When needed and appropriate, patients receive individual vocational counseling for the following:

- 2.1.1 interpretation of testing done;
- 2.1.2 discussion of aptitudes, interests, and attitudes toward work or training; motivation and employment potential;
- 2.1.3 discussion of vocational strengths, limitations, treatment goals, and recommendations;
- 2.1.4 discussion of skills and experiences in seeking employment;
- 2.1.5 discussion of educational/training needs and potential;
- 2.1.6 discussion of work habits related to tardiness, absenteeism, dependability, honesty, and relations with co-workers and supervisors;
- 2.1.7 discussion of personal, financial, and social matters related to vocational growth;
- 2.1.8 discussion of emotional and social adjustment related to vocational growth;

2.1.9 discussion of personal grooming and appearance; and

2.1.10 discussion of any other areas deemed necessary for maximizing the vocational growth and independence of the patient.

2.2 When needed and appropriate, patients receive group vocational counseling for the following:

2.2.1 discussion of and training regarding skills of daily living related to vocational growth and independence such as grooming, budgeting, using public transportation, finding a place to live, etc.;

2.2.2 discussion and training on job-seeking and survival skills related to vocational growth and independence;

2.2.3 remedial education and other academics related to vocational growth and independence; and

2.2.4 any other group activity deemed necessary for maximizing the vocational growth and independence of the patient.

3. As part of the Utah State Hospital Vocational Rehabilitation process, hospital staff refer appropriate patients to the Utah State Division of Rehabilitation Services. The Division of Rehabilitation Services staff work closely with the hospital staff to insure that vocational programs, services, and opportunities are used throughout the community to maximize the independent, productive functioning of Utah State Hospital patients.

3.1 Some of the services offered to hospital patients by the Division of Rehabilitation Services include:

3.1.1 counseling and planning;

3.1.2 development of an individual vocational treatment plan;

3.1.3 sponsorship in vocational evaluation;

3.1.4 sponsorship in sheltered work;

3.1.5 sponsorship in vocational training;

3.1.6 sponsorship in vocational schools, public and private;

3.1.7 sponsorship in colleges and universities;

3.1.8 sponsorship in tutorial, remedial, and special types of training;

3.1.9 sponsorship in on-the-job training or supported employment;

3.1.10 job placement assistance.

3.2 The Utah State Division of Rehabilitation Services staff meet with the Utah State Hospital Director of Rehabilitation Services, hospital administrative staff, unit staff, individual staff, and individual patients on an as-needed basis for vocational treatment planning for patients, for vocational program planning and development, and for conferences on individual patients. One staff member from the Utah State Division of Rehabilitation Services is assigned as primary liaison to Utah State Hospital.

3.3 Individual written rehabilitation plans, test results, progress reports, and

other pertinent information on patients are kept on file by the Division of Rehabilitation Services. This information is made available to appropriate Utah State Hospital staff on request, with signed release of information permission from the patient.

4. Vocational Rehabilitation staff assess patient industrial jobs available at Utah State Hospital according to their therapeutic value as related to types of patients. Vocational Rehabilitation staff make these jobs available to each unit within the hospital and monitor the industrial therapy program to insure that the following occurs:

- 4.1 The Unit Industrial Coordinator (environmentalist) monitors the availability of jobs available both on and off unit. Industrial assignments are given to patients after the needs of the patient has been addressed in a clinical staffing. Industrial assignments must be addressed in the Individual Comprehensive Treatment Plan (ICTP) and should be part of the recommendations made by USH Rehabilitation staff in the vocational assessment.

- 4.2 Individual referrals are made according to the following procedure: patients are clinically staffed, and where it is indicated that an industrial assignment would be therapeutic, the patient is referred by the social worker and environmentalist to vocational rehabilitation services for assessment, if necessary, and a specific job assignment. A completed referral form, W-4, and copy of the ICTP is given to Vocational Rehabilitation Services for approval. No patient can start an industrial assignment prior to the forms being received by vocational rehabilitation staff. After approval, the patient and environmentalist have a formal interview with the potential work supervisor. A copy of the industrial referral form is kept by the environmentalist, vocational rehabilitation and industrial job supervisor. If changes occur, such as re-assignment of an industrial assignment, a new referral slip is processed.

- 4.2.1 On-unit industrial therapy is limited to one hour per day and can not exceed five hours per week. A total of ten hours a pay period.

- 4.2.2 All on-unit training is limited to a maximum of three months from the initial start date. The initial start date is the date that has been approved by the rehabilitation department to start the patient.

- 4.2.3 All patients involved in the on-unit training will receive the current training fee of \$1.50 an hour not to exceed \$3.00 per hour.

- 4.2.4 All patients working off-unit other than forensic patients are limited to and will not exceed 20 hours a weekforty hours a pay period.

- 4.2.5 All patients working off-unit industrial training other than forensic patients will receive minimum wage.

- 4.3 Vocational Rehabilitation staff, unit industrial coordinators, industrial supervisors, and patient representatives meet bi-weekly to discuss patient productivity and progress, pay increases, industrial changes, miscellaneous problems, etc. This meeting is an integral part of the evaluation process for patients and the industrial therapy program. Vocational Rehabilitation staff meet regularly and as needed with industrial supervisors, unit industrial coordinators, and patients to ensure continuity of program, monitor patient progress, handle crises, decide on promotions and pay increases, etc. As part of the evaluation process, supervisors are expected to fill out the evaluation section of the patient's

biweekly time sheet at least monthly and preferably every two weeks.

4.4 The primary concern of the patient industrial program is that it be a therapeutic experience for the patient. Patients who work receive pay on a scale from \$1.50 to \$3.00 per hour. Higher rates of pay go to patient industrial assignments in highly technical or responsible areas such as the electrical shop, print shop, carpenter shop, paint shop, cooking, barbering, etc. Higher rates of pay also go to patients who are excellent workers or just for motivational purposes. The combined time sheet and evaluation form is kept on individual patients by the work supervisor and turned in every two weeks. The original goes to payroll, the yellow copy to the patient's chart, and the pink copy stays with the work supervisor for future reference.

4.5 Patients are not required to perform labor as a substitute for the operation and maintenance of the hospital or for which the hospital is under contract with an outside organization. The industrial program is a voluntary program and is for therapeutic and training purposes only. It is part of the patient's treatment, and no patient takes the place of a regular employee.

4.6 Patients on industrial assignments are directly supervised. Direct supervision is defined as the supervisor having visual contact with the patient at all times.

4.6.1 Patient candidates for an industrial, accompanied by the unit industrial coordinator and/or treatment coordinator, are interviewed by the potential industrial supervisor and are given a clear description of job duties and expectations. The patient may decline or accept the position, and the supervisor may accept or not accept the patient candidate.

4.6.2 Formal orientation is given to patients prior to their operating any power or dangerous equipment or tool.

4.6.2.1 Heavy equipment (*i.e.* backhoe, front loader, dump truck, caterpillars, cement trucks, etc.) are not operated by patients.

4.6.2.2 Dangerous equipment (*i.e.* drill presses, power saws, high voltage equipment, man handler, riding mower, etc.) are operated by patients only under direct supervision with prior orientation from an operations manual.

4.6.2.3 Dangerous equipment operation must be approved by the clinical team, industrial supervisor and must have signed documentation as to the training received.

4.6.3 There is open dialogue as needed between unit and assigned industrial supervisor relative to the patient's functioning or any changes thereof.

4.7 Some industrial assignments require driving of State Hospital vehicles. This is permissible upon the following stipulations being met.

4.7.1 The patient must be approved for driving privileges by his/her clinical team and assigned industrial supervisor with documentation in his/her chart. Civilly committed patients are not permitted to drive. (Reference: Functional Ability in Driving, Guidelines for Physicians,

Department of Public Safety, Category G "Psychiatric Disorders")

4.7.2 The patient must have a valid Utah drivers license in his/her possession.

4.7.3 The patient must have completed the Utah State Hospital Defensive Driving Course.

4.7.4 The patient must receive specific orientation to every vehicle he is required to drive with documentation in writing by their Industrial Supervisor and signed by the patient.

4.7.5 In vehicles that have safety belts, the belts must be worn.

4.7.6 Keys to all vehicles will be checked in and out daily by the patients with documentation in a log kept by the industrial area.

4.7.7 Anyone transporting patients or employees is responsible to see that the passengers are secured inside the vehicle and not riding on trailers or tractors, etc.

4.8 Patients on industrial assignments may have access to keys to specific designated working areas under the following guidelines:

4.8.1 Patients must be approved for key privileges by the unit clinical treatment team and the industrial supervisor.

4.8.2 Patients will not be allowed keys to the Pharmacy, Lab, Central Supply, Warehouse, X-ray, high voltage areas, med. rooms, Canteen, Business Office, Records Room, Library, Beauty Shop, Pool area, Weight room, AudioVisual room, recreation storage areas, Physical Therapy room, offices, patient living areas and offices.

4.8.3 Patients having key access will be oriented to safety factors of the specific work site.

4.8.4 Keys must be signed in and out to the supervisor at the beginning and ending of each shift.

4.8.5 Lost keys must be reported immediately to the industrial supervisor and could result in loss of industrial assignments.

4.8.6 Keys may not be duplicated without going through appropriate hospital request channels.

4.8.7 Key sets issued for patient utilization will have a numerical code system for accountability.

5. Reports and records are kept on vocational rehabilitation activities, including dates and descriptions of activities, participation in the results of activities, evaluation results, etc.

5.1 Assessment/Evaluation reports will be part of the patient's file with all its findings.

5.2 A patient's individual vocational rehabilitation plan will be stated in the patient's individual comprehensive treatment plan.

5.3 Evaluations, training and vocational rehabilitation plans, vocational notes, test results, etc., done by the Division of Rehabilitation Services are available through the division office by release of information permission from the patient.

5.4 To maintain accurate, up-to-date appraisal of patients, hospital staff will dictate or write rehabilitation notes on individual vocational sessions, group vocational sessions, and other pertinent happenings involving patient vocational rehabilitation activities.

5.5 The combined time-sheet and evaluation form, as described in 4.4, is done bi-weekly and is part of the patient's file.

6. The hospital's vocational rehabilitation service will have a sufficient number of appropriately qualified staff and support personnel to meet the needs of patients; implement quality vocational rehabilitation programs; and monitor the achievement of vocational objectives, equipment, methods, assessments, and programs used to foster the vocational independence of patients.

7. The Utah State Hospital Director of Vocational Rehabilitation Services is ultimately responsible for the direction and monitoring of all vocational rehabilitation programs, staff, professional standards, Division of Rehabilitation Services liaison, community liaison, consultation to administrative and unit staff, public relations, and education for vocational rehabilitation of hospital patients and the development and implementation of vocational rehabilitation programs.

8. As part of the hospital quality assurance program, the quality and appropriateness of patient care provided by the vocational rehabilitation service are monitored and evaluated and identified problems resolved.

8.1 The director of the vocational rehabilitation service is responsible for assuring that there is a planned and systematic process for the monitoring and evaluation of the quality and appropriateness of patient care and for resolving identified problems.

8.2 The quality and appropriateness of patient care are monitored and evaluated in all major clinical functions of the vocational rehabilitation service.

8.2.1 Vocational rehabilitation staff are monitored, trained, and formally assessed for competencies to perform in their assigned clinical functions.

8.3 When important problems in patient care or opportunities to improve care are identified:

8.3.1 actions are taken; and

8.3.2 the effectiveness of the actions is evaluated.

8.4 The findings from the conclusions of monitoring, evaluation, and problem-solving activities are documented and, as appropriate, are reported.

8.5 The actions taken to resolve problems and improve patient care, and information about the impact of the actions taken, are documented and, as appropriate, are reported.

8.6 As part of the annual re-appraisal of the hospital quality assurance program, the effectiveness of the monitoring, evaluation, and problem-solving activities pertaining to vocational rehabilitation services are evaluated.

8.7 The Utah State Hospital Quality Assurance Office works with the Director of Vocational Rehabilitation Services to monitor and evaluate the quality and appropriateness of patient care and to resolve identified problems. The Director of Quality Assurance is responsible for assuring that there is a planned and systematic process for such monitoring, evaluation, and problem-solving activities.

Note: For further, more detailed information regarding policies, procedures and program description, refer to the Vocational Rehabilitation Policies and Procedures Manual.

Implemented: 4-23-82

Revised: 11-25-85

Revised: 5-6-88

Revised: 5-24-89

Revised: 10-17-90

Revised: 2-91

Reviewed: 3-92

Revised: 2-93

Revised: 12-98

Reviewed: 8-01

Revised: 7-02

Chapter: lxvii Research and Evaluation (RE)

Section 1: Research Projects

Policy

1. Utah State Hospital (USH) conducts or participates in research projects only when the costs of the projects are justified by a potential to improve patient care. A rigorous review is made of the merits of each research project, particularly where human subjects are directly involved, and where there may be potential harmful effects of the research procedures on the participants as human subjects (patients or staff).
2. USH discourages research projects that involve inconvenience or risk to patients.

Procedure

1. Project design and review.
 - 1.1 USH staff members who have ideas about potential evaluation research projects are encouraged to discuss these ideas with the Manager of the Research Committee. The required approvals and time frames required for approval and completion of the project are also discussed.
 - 1.2 If in the judgment of the Manager of the Research Committee a project appears to have potential to improve some aspect of patient care, a prospectus on the project must be completed.
 - 1.3 The Manager of the Research Committee previews each prospectus to make recommendations to the Research Committee.
 - 1.3.1 If the investigator is a student, the student's faculty advisor must approve the plan. The student will then contact the Manager of the Research Committee to coordinate research planning.
 - 1.3.2 The Administrative Director of the hospital unit(s) to be involved in the research must be consulted and his/her written approval obtained.
 - 1.3.3 The USH director of the discipline of the principal investigator reviews any prospectus involving human subjects and gives an opinion in writing that the project meets the professional and ethical standards of the discipline.
 - 1.3.4 Copies of the prospectus for the research project are circulated to committee members prior to the next scheduled Research Committee Meeting.

1.4 The research project is presented to the Research Committee for discussion, suggestions, and conditional approval. The issue of informed consent is discussed. Where the research involves possible risks or discomforts beyond the usual treatment plan, the rationale for these risks must always be documented for special review by the total membership of the Research Committee. The minutes of the Research Committee meeting will contain the results of the committee review and will include copies of each such prospectus reviewed. A copy of these minutes is sent to the Superintendent and the Hospital Clinical Director.

2. Informed consent.

2.1 Individuals over the age of twelve and parents or guardians of individuals under the age of eighteen who are asked to participate in a research project must be informed regarding the project and sign a voluntary consent form.

2.2 Any disclosure of information that is deferred until the research project completion must be clearly and rigorously justified in the prospectus showing why such disclosure is inadvisable and that failure to give full disclosure is not detrimental to the participants.

2.3 For any project approved by the Research Committee that involves possible risk, the policies and procedures are followed as given on risk research. (See USHOPP, Special Treatment Procedures Chapter, Section 8 - Research that Involves Inconvenience or Risk to the Patient).

2.4 Neither the consent form nor any other written or oral agreement entered into by the participant may include any language that releases the facility, its agents, or those responsible for conducting the research from liability for negligence.

2.5 Prospective participants under the age of eighteen, and all prospective participants who are legally or functionally incompetent to provide informed consent, may participate only when and if, upon receiving the same information as would be given to the participant, a person legally empowered to consent signs a consent form.

3. Ethical standards and project reporting.

3.1 Persons directly involved in research, both in obtaining consent and in conducting research, are supervised by their respective discipline director to insure adherence to the ethical standards of their respective professions, and by the Manager of the Research Committee to insure that the conduct of research is guided by the regulations of the US Department of Health and Human Services and other federal, state, and local statutes and regulations concerning the protection of human subjects.

4. Final approval.

4.1 When the above required approvals are obtained, the investigator shall meet with the Manager of the Research Committee for final approval to begin the study.

5. Project reporting.

5.1 Upon completion of the research project, the principal investigator, whether a member of the USH staff or an outside researcher, is responsible for

communicating the results and possible theoretical implications to the Research Committee.

Implemented: 7-12-83

Revised: 6-15-88

Reviewed: 1-91

Reviewed: 9-95

Revised: 6-98

Reviewed: 2-02

Chapter: ^{lxviii} Risk Management (RM)

Section 1: Escorting and Transporting Patients in a State Vehicle

Policy

Patients escorted off hospital grounds are accompanied by appropriate staff.

State owned vehicles are provided for the purpose of transporting patients when needed. This includes, but is not limited to, medical appointments, shopping, recreational activities, etc.

Procedure

1. Whenever patients are transported in state vehicles the following applies:
 - 1.1 Patients who are considered high risk, are transported in the back seat only.
 - 1.2 Patients and staff properly utilize the vehicle seat belt whenever they are in a state vehicle.
 - 1.3 The "safety locking device" is engaged whenever a patient is being transported.
 - 1.3.1 Whenever a patient is being transported in a van that does not have a "safety locking device" and employee sits by the van side door to prevent the door from being opened while the vehicle is in motion.

*Implemented: 5-23-83
Reviewed: 1-14-86
Revised: 4-18-88
Reviewed: 12-90
Reviewed: 9-92
Reviewed: 9-95
Revised: 7-00*

Chapter:^{lxix} Risk Management (RM)

Section 2: Patient Vehicles

Policy

Patients may not store their vehicles on the Utah State Hospital for an extended period of time.

Procedure

1. In the event that a patient's vehicle is brought onto the hospital campus, a member of the treatment team obtains the keys to the vehicle and stores them in a secure box until disposition of the vehicle can be determined.
2. The patient's social worker contacts the patient's family or other person identified by the patient and requests that they make arrangements to have the vehicle moved from USH.
3. If the patient has no family or other person available to move the vehicle, the business office locates an appropriate storage facility for the vehicle.

- 3.1 The patient is responsible for all costs related to the storage of their vehicle

*Initiated: 9-98
Implemented: 11-98
Reviewed: 9-01*

Chapter: ^{lxx} Risk Management (RM)

Section 3: Americans With Disabilities Act (ADA)

Policy

No qualified individual with a disability shall, by reason of disability, be excluded from participation in or be denied the benefit of the services, programs, activities, or be subject to discrimination by the Utah State Hospital.

Procedure

1. The Utah State Hospital complies with all current Federal and State rules and policies of the Americans With Disabilities Act (ADA).
2. All clients, visitors, and employees that meet the guidelines for a disability and have a need or a concern for reasonable accommodation may request such in writing to the Utah State Hospital ADA Coordinator (Human Resource Director, 801-344-4568).
 - 2.1 Facility conditions that present a concern about access and safety are reported to Utah State Hospital Risk Management (801-344-4256).
3. All requests are reviewed by the Hospital ADA Coordinator and may be reviewed by an ad hoc committee.

*Initiated: 1-96
Revised: 6-98
Revised: 11-98
Revised: 11-01*

Chapter: ^{lxxi} Risk Management (RM)

Section 4: Employee Workplace Anti-Violence

Policy

Violence of any sort is prohibited by the Utah State Hospital. It is a shared obligation of all employees to individually or jointly act to prevent or diffuse actual or implied employeeeco-worker violent behavior in the workplace.

Procedure

1. All threats or acts of employeeeco-worker violence are immediately reported to a supervisor.
2. All such reported situations are reviewed by the Utah State Hospital Management, who then determines appropriate action..
 - 2.1 All action taken comply with applicable laws and policies.
 - 2.2 Resolutions are completed in a timely manner.
3. An employee who reports real or implied violent behavior will not be subject to retaliation or harassment due to their report.
 - 3.1 Retaliation or harassment by an individual will not be tolerated and the individual who is retaliating or harassing will be subject to disciplinary action.
 - 3.2 Persons making malicious or unfounded reports of violence are subject to administrative review andor action.

*Initiated: 1-96
Implemented: 3-96
Reviewed: 6-98
Reviewed: 3-02*

Chapter: lxxii Risk Management (RM)

Section 5: Reporting Abuse Neglect, Theft, and Criminal Activity

Policy

Employees of the Utah State Hospital report all incidents of abuse, theft, and any other criminal activity to proper authorities/departments.

Definitions

Abuse: (a) attempting to cause, or intentionally or knowingly causing physical harm or placing another in fear of imminent physical harm; (b) physical injury caused by criminally negligent acts of omission; (c) unlawful detention or unreasonable confinement; (d) gross lewdness; or (e) deprivation of life sustaining treatment except as provided for in Personal Choice and Living Will.

Arson: by use of fire or explosives, a person unlawfully or intentionally damages: (a) any property with intention of defrauding an insurer; or (b) the property of another.

Assault: (a) an attempt, with unlawful force or violence, to do bodily injury to another; (b) a threat, accompanied by a show of immediate force or violence, to do bodily injury to another, or (c) an act, committed with unlawful force or violence, that causes or creates a substantial risk of bodily injury to another.

Bodily Injury: physical pain, illness, or impairment of physical condition.

Child: a person under 18 years of age that is not an emancipated minor.

Disabled Adult: a person 18 years of age or older, who is impaired because of mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication, or other cause, to the extent that he/she is unable to care for his/her own personal safety or to provide necessities such as food, clothing, shelter, or medical care.

Elderly Adult: a person 65 years of age or older.

Emotional or Psychological Abuse: deliberate conduct that is directed at another person through verbal or nonverbal means, and that causes the person to suffer emotional distress or to fear bodily injury, harm, or restraint, where none existed before.

Harm or Threatened Harm: damage or threatened damage to the physical or emotional health and welfare of a person through neglect or abuse, and includes non-accidental physical or mental injury, incest, sexual abuse, sexual exploitation, molestation, or repeated negligent treatment or maltreatment.

Hospital Administration: the Superintendent, Assistant Superintendent, Clinical Director, Assistant Clinical Director, and Director of Nursing (this is not a Utah Code definition).

Incest: having sexual intercourse with a person whom the perpetrator knows to be his or her ancestor, descendant, brother, sister, uncle, aunt, nephew, niece, or first cousin.

Molestation: touching the anus or any part of the genitals of a disabled person or otherwise taking liberties with a disabled person, or causing a disabled person to take indecent liberties with the perpetrator or another with the intent to arouse or gratify the sexual desire of any person.

Neglect: failure by a caretaker to provide care, nutrition, clothing, shelter, supervision, or medical care.

Person Responsible for Child's Care: the child's parent, guardian, employee of the hospital responsible for the child's care, or other person responsible for the child's care, whether in the same home as a child, a relative's home, a group, family, or day care facility.

Rape Object Rape: (1) sexual intercourse with another person without the victim's consent; penetration, however slight, of the genital or anal opening of another person who is 14 years of age or older, by any foreign object, substance, instrument, or device, not including a part of the human body, with intent to cause substantial emotional or bodily pain to the victim or with the intent to arouse or gratify the sexual desire of any person. (2) A person commits rape of a child when the person has sexual intercourse with a child who is under the age of 14; penetration or touching, however slight, of the genital or anal opening of a child who is under the age of 14 by any foreign object, substance, instruments, or device, not including a part of the human body, with intent to cause emotional or bodily pain to the child or with the intent to arouse or gratify the sexual desire of any person.

Sexual Abuse: acts or attempted acts of sexual intercourse, sodomy, or molestation directed toward a disabled person.

Sexual Exploitation: knowingly employing, using, persuading, inducing, enticing, or coercing any disabled person to pose nude for the purpose of photographing, filming, recording, or displaying, distributing, possessing for the purpose of distribution, or selling material depicting disabled persons in the nude or engaging in sexual or simulated sexual acts.

Theft: obtaining or exercising unauthorized control over the property of another with a purpose to deprive the other person thereof.

Procedure

CRITERIA FOR IDENTIFYING VICTIMS OF ABUSE:

The following criteria is used on the initial assessment and the re-assessment of patients:

Criteria for Identifying Abuse of a Child:

1. Types of Abuse:

1.1 Physical: Non-accidental use of physical force that results in bodily injury, pain, or impairment.

1.2 Neglect: Failure to provide adequate food, medical treatment, clothing, shelter, or protection. (Cases of neglect are less likely to be reported than cases of physical or sexual abuse.)

1.3 Psychological Abuse: Willful infliction of mental or emotional anguish by

threat, humiliation, intimidation, or other verbal or non-verbal abusive conduct.

1.4 Sexual Abuse: Sexual activity or molestation between a minor and an older person.

2. Possible Indicators:

2.1 The child...

- a. has an unexplained injury.
- b. shows evidence of dehydration and/or malnutrition without obvious cause.
- c. has been given inappropriate food, drink, and/or drugs.
- d. shows evidence of repeated injury.
- e. "takes over" and begins to care for parent's needs.
- f. is seen as "different" or "bad" by the parents, care givers, or peers.
- g. is secluded or restrained without a doctor's order, or left in restraints/seclusion longer than is necessary.
- h. is dressed inappropriately for type of activity or season.
- i. shows evidence of repeated skin injuries.
- j. shows evidence of repeated fractures.
- k. shows evidence of "characteristic" x-ray changes to long bone.
- l. has injuries that are not mentioned in history by care giver.
- m. has stable injury.
- n. has rectal bleeding.
- o. has vaginal discharge or bleeding.
- p. has made a suicide attempt.
- q. has dysuria/hematuria.
- r. complains of being harmed.

2.2 The person responsible for the child's care...

- a. shows evidence of loss of emotional control, or fear of losing such control.
- b. presents contradictory developmental history.
- c. projects cause of injury onto a sibling, peer, or third party.
- d. has delayed unduly in seeking necessary care.
- e. shows detachment.
- f. reveals inappropriate awareness of seriousness of situation (either over-reaction or under-reaction).

- g. continues to complain about irrelevant problems unrelated to the child's needs.
- h. uncooperative; hesitating or refusing to disclose history and information.
- i. gives specific "eye witness" history of abuse.
- j. obtains no one to assist him/her when unable to deal with child.
- k. gives a history of repeated injury.
- l. is reluctant to give information
- m. tries to remove child before a thorough assessment is performed.
- n. demands instant treatment and/or other inappropriate treatment.
- o. gives contradictory or inconsistent versions of the injury causing incident.

Criteria for Identifying Abuse of a Disabled or Elderly Adult:

1. Types of abuse:

1.1 Physical Abuse: Willful, direct infliction of physical pain or injury. Denial of physical and health related necessities of life. Inappropriate confinement of patient.

1.1.1 Possible indicators:

- a. Unexplained alopecia, abrasions, bruises, burns, bumps, contusions, falls, fractures, grip marks, hematomas, immobility, infections, internal injuries, lacerations, pain, restricted movement, object marks, swelling, tenderness, ulcers, welts.
- b. Pain, bruising, bleeding in genital areas.
- c. Forced to take medications when not medically indicated and outside of the involuntary medication policy.
- e. Is secluded or restrained without doctor's order, or left in restraints/seclusion longer than necessary.

1.1.2 Profile of abuse victim:

- a. Abnormal progression of physical and/or mental impairment as a consequence of no treatment.
- b. Denies abuse, reluctant to report.
- c. May feel abuse is deserved.

1.1.3 The care giver, family or responsible party:

- a. Responds defensively when questioned, makes excuses, hostile, suspicious, irritable, demanding.
- b. May be unconcerned towards patient.
- c. Treats patient like a non-person in a demanding inhumane

manner.

- d. Has minimal eye, facial, physical, verbal contact with patient.

1.2 Neglect: Lack of attention, abandonment, or inappropriate confinement of the patient.

1.2.1 Possible Indicators:

- a. Appears malnourished, emaciated, dehydrated, with mouth sores, confusion.
- b. Has impaired skin integrity, decubitus ulcers, rashes, urine burns, soiled linens, unkempt appearance.
- c. Clothes in poor repair, inappropriate for season.
- d. Required treatment not given.
- e. Is not allowed to participate in treatment decision process when able.
- f. Doesn't have assistive devices such as glasses, hearing aid, dentures, despite availability of resources.
- g. Is left unattended when in restraints or safety devices.
- h. Muscle contracture, immobility, weakness unexplained by medical condition..

1.3 Psychological Abuse: Removal of decision making power for the patient when competent, withholding of support, social isolation.

1.3.1 Possible Indicators:

- a. Appears ashamed, low self-esteem, withdrawn. Waits for care givers to supply answers to questions.
- b. Is denied visitors, phone calls, communication by mail, or church attendance without adequate explanation.
- c. Lack of interest or desire; is depressed, hopeless, helpless.
- d. Is not included in treatment planning process when capable of doing so.

1.4 Exploitation: Any situation involving the dishonest use of a patient's resources, such as money or property. Misappropriation of health care resources.

1.4.1 Possible Indicators:

- a. Medical under-treatment.
- b. Inappropriate transfer within institution.
- c. Nursing attitudes such as lack of understanding, custodialism, paternalism.
- d. Use of patient's possessionsproperty investments for personal gain.

- e. Disappearance of patient possessions.
- f. Required to do work which is not a part of routine patient activities or which is not prescribed in the treatment plan.

Criteria for Determining Domestic or Peer Abuse

1. Definition: The use of violence between spouses or peers.

1.1 Possible Indicators:

- a. A variety of symptoms such as low back pain, headache, chest pain, anxiety, depression, sleep disorders, chronic pain syndrome, and suicide attempts, but does not present with true problem.
- b. Locations of injury(ies): face, extremities, skull, eyes, chest, ribs, upper back, abdomen, pelvis, lower back, neck.
- c. Types of injuries: bruises, laceration, muscularskeletal, chocking, internal injuries, loss of consciousness, burns, scalds, sexual assault, bites, knifegun wounds, and homicidal deaths.

REPORTING ABUSE OF PATIENTS PROCEDURE:

1. In accordance with UCA 62A-3-205(1) and 62A-4a-403, 76-5-111.1 any person who has reason to believe that a child or disabled adult has been the subject of abuse during hospitalization (including, but not limited to: incest, molestation, sexual abuse, physical abuse, assault, psychological abuse, etc.) shall immediately notify the Division of Child and Family Services (DCFS) Child Protective Services (CPS) [1-800-341-7005], or Adult Protective Services (APS) [1-800-371-7897]. Utah State Hospital Risk Management, and/or the Provo police are also notified. (See attached list for regular business hours and after hours reporting.)

1.1 The person then notifies the Hospital Risk Management Office by e-mail to "Risk Management", phone or voice mail.

1.2 The person making the report then completes an Incident Report Person Incident Reporting System and files it with the Hospital Risk Management Office, including in the report who has been notified.

1.3 Anyone who willfully fails to report such an incident is guilty of a class B misdemeanor and is subject to hospital and Department disciplinary actions.

2. The Risk Management Office immediately notifies the Hospital Superintendent and Hospital Clinical Director.

2.1 If the incident occurs after 5 p.m. or on a weekend or on a holiday, the person making the report immediately notifies the Shift Supervisor Registered Nurse (SSRN) who then notifies the Administrator on-call.

3. The hospital Risk Management Office communicates with Child Protective Services (CPS) and Adult Protective Services (APS) to review incidents of alleged abuse.

4. In the event that the Hospital Administration determines to conduct an internal inquiry or investigation, the level of investigation is determined with consultation from Hospital Risk Management (no internal investigation is initiated without direction from Hospital Administration) and may include:

- 4.1 UnitService area conducts an investigation;
 - 4.2 Risk Management Office conducts an investigation; and/or
 - 4.3 Hospital Administration requests an external investigation.
5. Once a decision has been made by Hospital Administration as to which level of investigation is to be initiated, the service management team and Risk Management are notified.
6. Service Area Investigation Procedure: when a UnitService Area investigation has been directed, the procedure is as follows:
 - 6.1 The UnitService Area management team meets with each employee, patient, and/or any other person involved or who has knowledge of the reported incident.
 - 6.2 The UnitService Area management team sends a report of its findings, conclusions, and recommendations to Hospital Administration and Risk Management. Findings are then shared with the complainant and the accused.
 - 6.2.1 Risk Management maintains a file of all investigations, findings, and conclusions. This file is not part of any hospital medical record.
 - 6.2.2 When appropriate, Human Resources is provided documentation when it pertains to a specific employee.
 - 6.3 State and local agencies may be informed of findings and conclusions, when appropriate.
7. Hospital Risk Management Investigation Procedure: when an internal investigation has been directed, the procedure is as follows:
 - 7.1 The Hospital Administration makes an assignment to Risk Management to conduct an investigation.
 - 7.2 The investigation team meets with each employee, patient, and/or any other person involved or who has knowledge of the reported incident.
 - 7.3 The investigation team sends a report of findings and conclusions to the Hospital Administration.
 - 7.3.1 Risk Management maintains a file of all investigations, findings, and conclusions. This file is not part of any hospital medical record.
 - 7.4 The Hospital Administration coordinates with service area administration to determine actions based on the investigation.
 - 7.5 The Hospital Administration forwards the investigation report to USH Human Resources for filing, if information is pertinent to specific employees.
 - 7.6 The Hospital Administration or designee sends a letter of findings, as appropriate, to the complainant and the accused.
8. External Investigation Procedure: when an external investigation has been directed, the procedure is as follows:
 - 8.1 The Superintendent or Assistant Superintendent requests an external investigation team (Division of Substance Abuse and Mental Health/Department of

Human Services State Agency or other) conduct an investigation.

8.1.1 Risk Management may assist with the investigation, if deemed appropriate.

8.2 The investigation team sends a report of findings and conclusions to the Hospital Administration and Risk Management.

8.3 The Hospital Administration coordinates with service area administration to determine actions based on the investigation.

8.4 The Hospital Administration forwards the investigation report to Human Resources for filing, if information is pertinent to specific employees.

8.5 The Hospital Administration or designee sends a letter of findings, as appropriate, to the complainant and the accused.

8.5.1 Copies of the letters and other appropriate documentation is given to the Hospital Risk Management Office.

8.5.2 Risk Management maintains a file of all investigations, findings, and conclusions. This file is not part of any hospital medical record.

9. When an investigation is being conducted by local police or any other state agency, that authority agency determines the procedure it will follow to complete its investigation.

9.1 Hospital personnel may assist if requested by the agency conducting the investigation.

REPORTING CRIMINAL ACTIVITY PROCEDURE:

1. Any employee who witnesses or has knowledge of any illegal or criminal activity occurring on the Utah State Hospital campus or in connection with hospital-sponsored events or activities immediately reports the incident to Risk Management and to Hospital Administration. "Criminal Activity" includes, but is not limited to: theft, arson, burglary, assault, reckless driving, graffiti, robbery, etc.

1.1 The person making the report completes an Incident Report and files it with the Hospital Security Office.

1.2 Hospital Security forwards a copy of the report to the Risk Management Office.

2. Risk Management notifies Hospital Administration after its initial assessment of the reported incident.

3. Hospital Security initiates an investigation.

3.1 Hospital Security may involve local police.

3.2 Hospital Security reports the progress of its investigation to Risk Management.

4. At the completion of the investigation, all findings and conclusions are reported to Hospital Administration and Risk Management.

5. Investigation reports are sent to Human Resources for filing, if information is pertinent to specific employees.

- 5.1 The Hospital Risk Management Office maintains a file of all investigations, findings, and conclusions. This file is not part of any hospital record.
6. USH Security maintains a file of its investigations and results in its office.

FILING CHARGES PROCEDURE:

1. Criminal charges may be filed against employee or visitors for violations alleged to be criminal. Hospital administration is contacted by Utah State Hospital security before filing criminal charges.
 - 1.1 Utah State Hospital Security Officers follow protocols in filing charges as outlined in the Security Manual, Filing Charges Procedures.
2. The Utah State Hospital may file criminal charges against patients who violate the law.
 - 2.1 At the time of the alleged criminal incident, hospital employees contact Utah State Hospital security and provide oral testimony regarding the event(s).
 - 2.2 The Utah State Hospital security investigating officer completes and submits a criminal report by the end of shift.
 - 2.3 The Hospital Chief of Security reviews all criminal reports.
 - 2.4 The decision to file charges is made by the Chief of Security after considering the following:
 - 2.4.1 Probable cause that a criminal offense was committed.
 - 2.4.2 Probable cause exists that a patient committed the offense.
 - 2.4.3 Severity of the crime, ie., injuries, severity of injuries, etc.
 - 2.4.4 The Chief of Security makes contact with the unit SMT who assesses the patient's mental condition and decides if it is in the best interest of the patient to press charges. If it is felt that it is in the best interest of the patient (treatment for conduct problems, consequence learned behaviors, connecting behaviors with consequences), then the SMT will provide a letter stating this, which will accompany the charges. If it is not felt to be in the best interest of the patient to file charges, then no letter will be sent and the criminal report will be filed by security internally.
 - 2.4.5 If the alleged victim disagrees with the decision involving the filing of charges, he/she may contact the county or city attorney and pursue the matter of legal charges separately and independently from the hospital. The hospital will provide the original criminal report upon request to the city or county attorney.
 - 2.5 After completing the review process, all viable criminal charges are filed with the appropriate local authorities.
 - 2.5.1 Copies of the filed reports are sent to risk management office, executive staff, and the unit SMT by the security department.
 - 2.5.2 When the Chief of Security receives notification of actions to be taken by the city/county attorney's office, the risk management office, the executive staff, and unit SMT are immediately contacted.

2.5.3 If notification is not received within 30 days security will follow up with the citycounty attorneys office and report back to risk management, executive staff, and unit SMT.

Implemented: 4-97

Revised: 7-99

Revised: 8-01

Revised: 1-03

Chapter: ^{lxxiii} Risk Management (RM)

Section 6: Tarasoff Warning

Policy

In accordance with UCA 78-14a-102, the Utah State Hospital makes reasonable effort to notify persons who are the subject of a threat made by a patient residing at the hospital, or when a victim requests to be notified of a patient's discharge.

Procedure

1. Whenever a patient communicates to a staff member an actual threat of violence toward an identifiable, or reasonable identifiable person, that staff member documents the threat in the chart and reports it to the Legal Services Managerdesignee and Unit Administrative Director. The Legal Services Manager or designee notifies a law enforcement officer or agency.
 - 1.1 A victim may also request that heshe be notified when a patient is away from the hospital or is discharged.
2. The Legal Services Managerdesignee makes reasonable effort to contact the person or persons who are the subject of the threat and then notifies a law enforcement officer or agency. Documentation of the attempts and contact will be kept by the Legal Services Managerdesignee initially and placed in the patient's permanent chart after six months.
3. The unit administrative director or designee informs the unit of the person or persons to be notified should the patient elope, go on a home visit, go on therapeutic leave, or be discharged.
 - 3.1 The Tarasoff Warning is placed on the outside of the patient's working chart by the Unit Administrative Directordesignee.
4. Prior to a patient going on a home visit, going on therapeutic leave, or being discharged, the Unit Administrative Director is responsible to contact those persons listed on the Tarasoff Warning.
 - 4.1 The Unit Administrative Director may delegate this responsibility if necessary.
 - 4.2 In the event that the patient elopes, the Unit Administrative Directordesignee is responsible to contact those persons listed on the Tarasoff Warning as soon as reasonably possible.
 - 4.2.1 In the event that the patient elopes after regular working hours, on a weekend, or on a holiday, the unit is responsible to notify the psychiatrist

on-call and the administrator on-call who then designate a staff member to contact those persons listed on the warning.

5. Notification of those persons listed on a Tarasoff Warning is documented in the chart and a copy is provided to the Legal Services Managerdesignee.

Implemented: 6-97
Revised: 10-00

Chapter^{lxxiv}: Risk Management (RM)

Section 7: Health and Safety Program

Policy

In accordance with, the Utah Occupational Safety and Health Act, the Utah State Hospital maintains a health and safety program.

Procedure

1. The Utah State Hospital implements safety standards, procedures, and practices to ensure the safety of employees, patients, and members of the public.
2. Safety standards, procedures, and practices are provided to employees during orientation and inservices are provided as needed. (For specific plans see the Risk Management Policy and Procedure Manual.
3. Each service area conducts periodic safety inspections of their areas.
4. Accidents, incidents, and safety hazards are reported to the immediate supervisor and Risk Management.
 - 4.1 Appropriate forms are completed and sent to Risk Management.
5. The Environment of Care Safety Committee reviews reported incidents, safety inspections, and reported hazards on a quarterly basis.
 - 5.1 The Environment of Care Committee provides recommendations for corrective actions to service areas when needed.

Initiated: 12-98
Revised: 7-01

Chapter^{lxxv}: Risk Management (RM)

Section 8: Administrative Death Review

Policy

Utah State Hospital reviews the deaths of patients and employees that occur at Utah State Hospital. Utah State Hospital also reviews the deaths of patients occurring within twelve (12) months of discharge from the hospital, when known. The purpose of the death review is to determine if patient care or hospital safety could be improved. Those participating in the death review process make recommendations for patient care, hospital safety, training and education, and revisions to policies and procedures, as needed.

Procedure

1. Utah State Hospital is in compliance with Utah Code Annotated statutes, and the Department of Human Services Policy and Resource Manual.

- 1.1 "Fatality Review," Department of Human Services, Policy and Resource Manual.

- 1.2 The Utah State Hospital Clinical Risk Manager is designated as the facility Fatality Review Coordinator, and is responsible for the implementation of this policy and procedure.

2. "Deceased Client or Employee Report"

- 2.1 The Clinical Risk Management sends the following individuals a copy of the "Deceased Client or Employee Report," within three (3) days of notification of death.

- 2.1.1 Utah State Hospital

- 2.1.1.1 Superintendent

- 2.1.1.2 Clinical Director

- 2.1.1.3 Assistant Superintendent

- 2.1.1.4 Assistant Clinical Director

- 2.1.1.5 Risk Management

- 2.1.1.6 Public Relations

- 2.1.1.7 Medical Staff Coordinator

- 2.1.1.8 Medical Records

- 2.1.1.9 Director of Medical Services

- 2.1.2 Director of the Division of Substance Abuse and Mental Health

- 2.1.3 Director of the Department of Human Services
- 2.1.4 Department of Human Services Fatality Review Coordinator
- 2.1.5 Assistant Attorney General for Utah State Hospital
- 2.1.6 Director of State Risk Management

2.2 Any employee who becomes aware of the death of a discharged patient within twelve(12) months of discharge immediately notified the Utah State Hospital Risk Management Office.

3. A Risk Management Fatality Review (Level 1 Review) occurs for all patient deaths, up to twelve (12) months of discharge, when known. The Risk Management Fatality Review also occurs for all employee deaths related to Utah State Hospital employment.

3.1 The Utah State Hospital Clinical Director, and the Risk Management Office review all deaths of patients and employees when related to State Hospital Employment.

3.1.1 The Hospital Clinical Director and the Clinical Risk Manager review the patient's medical record.

3.2 The Utah State Hospital Risk Management Office conducts interviews, as appropriate, with staff, or others who are knowledgeable about the death.

3.3 An additional clinical specialist(s) whose knowledge or expertise could significantly contribute to the review process may review records at the direction of the Hospital Clinical Director.

3.4 The Clinical Risk Manager forwards a protected copy of the "Risk Management Fatality Review Report" to the Utah State Hospital Superintendent, Hospital Clinical Director, and Department of Human Services Fatality Review coordinator immediately upon completion.

4. A Medical Staff Death Review (Level II Review) occurs for all patients whose death occurs while an in-patient or within fourteen (14) days of discharge.

4.1 The Death Review is scheduled for the next meeting of the Medical Staff or Medical Executive Committee Leadership Group (within 15 days) after receipt of the death certificate.

4.1.1 If an autopsy is performed, the Medical Executive Committee Death Review is scheduled within fifteen (15) days after the Medical Examiner's Report is received.

4.2 Those notified to participate in the Death Review by the Medical Executive Committee include:

- 4.2.1 Clinical staff from the patient's unit
- 4.2.2 Utah State Hospital Medical Staff members
- 4.2.3 Those individuals notified of the death representing Utah State Hospital (see 2.1.1)
- 4.2.4 Other individuals whose knowledge or expertise could contribute to the review process.

4.3 Those individual representing the Division of Substance Abuse and Mental Health (2.1.2), Department of Human Services (2.1.4) and a member of the Board of Mental Health are requested to participate in the Medical Staff Death Review if the death was the result of any of the following:

4.3.1 Death by violence, gunshot, suicide, accident, or injury.

4.3.2 Sudden death while in apparent good health.

4.3.3 Death under suspicious or unusual circumstances.

4.3.4 Death resulting from poisoning or overdose of drugs.

4.4 The Medical Executive Committee Death Review examines the following:

4.4.1 What was the cause of death?

4.4.2 Were agency policies and procedures followed?

4.4.3 How did the system respond?

4.4.4 Are modifications of policies, procedures, laws, or training needed?

4.4.5 Are there additional recommendations?

5. Reports

5.1 The Clinical Risk Manager completes the "Deceased Client or Employee Report" within three (3) working days of notification of death.

5.2 The Clinical Risk Manger forwards a protected copy of the "Risk Management Fatality Review Report" to the Utah State Hospital Superintendent, Hospital Clinical Director, and Department of Human Services Fatality Review coordinator immediately upon completion.

5.3 The Medical Staff Coordinator sends a "protected" copy of the minutes of the Medical Executive Committee Death Review within fifteen (15) days to the Clinical Risk Manager who forwards it to the director of the Division of Substance Abuse and Mental Health and Fatality Review Coordinator of the Department of Human Services.

5.3.1 An action plan for implementing the Medical Executive Committee Death Review recommendations is included, as indicated.

Initiated: 8-01

Revised: 8-03

Section 1: Availability, Organization, Staffing, and Integration with Other Services

Policy

Social work services are readily available to the patient, the patient's family, and other persons significant to the patient; are well organized, properly directed, and staffed with a sufficient number of qualified individuals; and are appropriately integrated with other units and departmentsservices of the hospital.

Procedure

1. Social work services are delivered by social workers assigned to unit treatment teams, with the unit Administrative Director, and Director of Social Work having responsibility for the supervision and direction of each social worker. The social worker joins with other unit team members in clinical staffings and other treatment focused meetings and contributes hisher clinical insights and skills in the formation and implementation of treatment plans.
2. Clinical, functional supervision, consultation, in addition to line supervision, are available to all social workers. The Social Work Director assigns specific social workers as needed to serve as Lead Social Workers for each unit.
3. All social workers employed at the hospital are licensed by the State of Utah Department of Commerce, Division of Occupational and Professional Licensing as clinical social workers or certified social workers.
4. In addition to administration, there are sufficient social workers in clinical staff positions to cover the treatment units. Each patient is assigned a social worker who gives input into that individual's treatment plan.
5. Social Work Services supports the hospital's mission statement. Because of the hospital's specialization of treatment units, the treatment philosophy and programs may differ from unit to unit.

Implemented: 6-6-89

Reviewed: 1-91

Revised: 4-92

Revised: 6-93

Revised: 9-95

Revised: 12-98

Revised: 2-02

Chapter: ^{lxxvii} Social Work Services (SO)

Section 2: Personnel Training and Education

Policy

Social Work Services personnel are prepared for their responsibilities in the provision of social work services through appropriate licensing, training, and educational programs.

Procedure

1. Prior to being employed at Utah State Hospital, all social workers must be licensed with the Department of Commerce, Division of Occupational and Professional Licensing.
2. During their first year of employment, social workers receive supervision, orientation and/or training, in:
 - 2.1 Social History Assessments
 - 2.2 Treatment and Discharge Planning
 - 2.3 Individual Therapy
 - 2.4 Group Therapy
 - 2.5 Family Therapy
 - 2.6 Community Services:
 - 2.6.1 Community mental health services:
 - 2.6.1.1 Civil court mental health law.
 - 2.6.1.2 Criminal court mental health law.
 - 2.7 Supervision of students:
 - 2.7.1 Undergraduate students.
 - 2.7.2 Graduate students.
 - 2.7.3 Collegial toward LCSW.
 - 2.8 Current USH New Employee Orientation

- 2.9 Social Work Policies and Procedures
- 2.10 Unit Policies and Procedures
- 2.11 Hospital Policies and Procedures
- 2.12 Confidentiality
- 2.13 Documentation:
 - 2.13.1 Social Histories.
 - 2.13.2 Assessments.
 - 2.13.3 Progress notes.
 - 2.13.4 Individual Comprehensive Treatment Plans.
- 3. Social workers participate in inservice training offered at USH.
- 4. The Director of Social Work has the responsibility to identify and provide needed social work training.
- 5. Outside continuing educational opportunities are provided whenever feasible by USH.
- 6. All social workers are encouraged to be working toward receiving and maintaining LCSW licensure.
- 7. Social workers will fulfill requirements as outlined in the document "Social Work Competencies at Utah State Hospital".
- 8. Documentation of hospital, discipline, or unit inservice is kept in the social worker's personnel file in the Human Resource office.

Implemented: 6-6-89

Reviewed: 1-91

Revised: 4-92

Reviewed: 6-93

Revised: 9-95

Revised: 12-98

Revised: 2-02

Chapter: lxxviii Social Work Services (SO)

Section 3: Documentation

Policy

Adequate documentation of the social work services provided is included in the patient's medical record.

Procedure

1. Each patient is assigned a social worker who provides documentation in the patient's medical record.
2. Documentation includes but is not limited to weekly progress notes for the first eight weeks following admission and a minimum of monthly progress notes thereafter.
3. A social history is completed for each patient within 14 days of admission for patients at USH for treatment.
 - 3.1 A social history is completed within 72 hours on ARTC.
4. The social worker is responsible for participating with other unit clinical team members in the formulation of the patient's Individualized Comprehensive Treatment Plan. The social worker will document the patient's progress as it relates to the treatment plan goals.

*Implemented: 6-19-89
Reviewed: 1-91
Reviewed: 4-92
Revised: 6-93
Reviewed: 9-95
Revised: 12-98
Revised: 2-02
Revised: 9-02
Revised: 4-03*

Chapter: ^{lxxix} Social Work Services (SO)

Section 4: Physically Disabled Patients

Policy

Social Work Services provides for assessment and intervention relative to the unique needs of the physically disabled patient.

Procedure

1. The Social History will include any pertinent information regarding the physical disability of the patient. (i.e. trauma, coping skills, support systems, etc.)
2. The social worker will work with the clinical team to insure that the physically disabled patient receives appropriate clinical treatment.
3. As part of the discharge planning, the social worker will identify the special needs (i.e. living arrangements, income, transportation, etc.) of the physically disabled patient to the community liaison.

Implemented: 6-19-89

Reviewed: 1-91

Revised: 4-92

Reviewed: 6-93

Revised: 12-98

Reviewed: 2-02

Chapter: ^{lxxx} Special Treatment Procedures (SP)

Section 1: Less Restrictive Alternatives to Restraint and Seclusion

Policy

Utah State Hospital will strive to eliminate the use of seclusion and restraint by achieving better understanding of patients and providing more therapeutic interventions.

1. When a patient is agitated or upset and exhibits a potential for causing harm to self or others, the least restrictive alternative to restraint and/or seclusion is considered.
2. Safety devices used to support physically incapacitated patients, such as orthopedic appliances, surgical dressings, bandages, and posey belts used to prevent patients from falling out of wheelchairs, shower chairs, or beds are exceptions to Special Treatment Procedures, and are not regarded as restraint or seclusion procedures. (See Nursing Policy and Procedure Manual.)

Procedure

1. Less Restrictive Alternatives: Less restrictive alternatives include, but are not limited to:
 - 1.1 Use of deescalation procedures collaboratively identified by the patient and staff.
 - 1.2 Natural/Logical Consequences, Restrictions, or Limit Setting: Therapeutic community rules and/or individualized patient programs are negotiated through patient and staff involvement. Application of these firm limits and natural/logical consequences precedes, and may avoid the need for, restraint or seclusion.
 - 1.3 Time-Out (TO): Time-out is brief, voluntary time in an unlocked room of a patient who is extremely anxious or acting out. The purpose is to minimize stimulation in order to allow the patient to calm down without having to use more restrictive alternatives. Each time-out is recorded in the progress notes documenting rationale for the use of time-out and the length of time patient spent in time-out.
 - 1.4 One-to-One (1:1): The staff member must remain with the patient, within a

reasonable distance as required by the circumstances, at all times. A 1:1 requires a doctor's order stating the rationale for its use. An RN may initiate a nursing order for a 1:1 based on a nursing assessment; the RN must call physician or OD for formal order. A 1:1 requires the RN to make a note at least once a shift indicating the patient's status. A staff member assigned to do a 1:1 watch is not to leave their 1:1 patient assignment until the RN has assigned another staff member to do the watch and that staff member is present to relieve them.

1.5 Direct Observation Status (DOS): DOS requires that staff maintain continuous direct visual observation of the patient. The patient's head and hands must be in full view. DOS requires a doctor's order which shall include the rationale for DOS. The DOS watch must be done in the physical presence of the person, face to face, unless the doctor's order specifically states under what times or circumstances a video camera may be used. A DOS order does not limit a patient to a specific area. If the patient is to be confined to a room or area, an order for area restriction must be written. If 15 minute checks or area restriction is necessary, a separate order for each is required. Patients on DOS are to be involved in treatment and programming to the extent possible. The patient to staff ratio for DOS watch is to be determined by the unit staff. However, the ratio is not to exceed one (1) staff per six (6) patients. Each patient on DOS is to have a regular room assigned where belongings may be stored. The RN writes a note about the DOS patient on each shift. The note should include a statement about the reason for the patient being on DOS. A staff member assigned to do a DOS watch is not to leave the watch assignment until the RN has assigned another staff member to do the watch and that staff member is present to relieve them.

1.6 Area Restriction (AR): AR is the restriction of a patient to a given area within the patient community or restriction of the patient's access to a certain area. AR requires a doctor's order including the rationale for the order. An area restriction order is not to exceed seven (7) days without renewal. If the patient leaves the assigned area, staff must directly supervise him or her. Patients on AR are to be involved in treatment and programming to the extent possible. If DOS and/or 15-minute checks are necessary, a separate order for each in addition to the area restriction order is required. A note about the patient on AR is to be written by the RN each shift. The note should include a statement about the reason for the patient on AR.

2. The above interventions may be initiated by the RN on the unit. The RN must obtain an order from the physician on a 1:1, DOS, or AR within one hour of the initiation of the intervention.
3. These less restrictive alternatives shall not be used as punishment or for the convenience of staff.

Implemented: 3-25-83

Revised: 3-13-86

Revised: 3-25-88

Reviewed: 4-92

Reviewed: 9-95

Revised: 3-99

Revised: 4-00

Revised: 10-00

Revised: 11-01

Revised: 7-02
Revised: 5-04

Chapter: ^{lxxxi} Special Treatment Procedures (SP)

Section 2: Restraint and Seclusion

Policy

Restraint and seclusion are used only as safety measures of last resort and only in emergencies. A patient's rights, dignity, and well-being are protected during and after the use of seclusion or restraint.

Definitions

1. Restraint is any involuntary method of physically restricting a person's freedom of movement, physical activity, or normal access to his or her body. Application of a medical safety device is not considered a psychiatric restraint.
2. A Medical Safety Device is the use of a device intended to meet the assessed need of a patient for adaptive support or protection, for purposes of medical dental surgical or diagnostic procedures or for the purposes of healing.
3. Seclusion is the involuntary confinement of a person alone in a room away from the patient community where the person is physically prevented from leaving.
4. Emergency is a dangerous situation in which there is imminent risk of a patient physically harming himself/herself or others.

Procedure

Restraint and/or Seclusion are implemented under the following procedures:

1. Attending Psychiatrist or Designee:
 - 1.1 Conducts a clinical assessment of the patient to ascertain that the restraint and/or seclusion is necessary and that an emergency exists. If the physician is not present the unit charge nurse performs this assessment and reports it to the physician. The psychiatrist:
 - 1.1.1 Reviews with staff the physical and psychological status of the individual.
 - 1.1.2 Determines whether restraint or seclusion should be continued.

1.1.3 Supplies staff with guidance in identifying ways to help the individual regain control in order for restraint or seclusion to be discontinued, and

1.1.4 Supplies an order.

1.1.4.1 If the physician feels the restraint use is for medical purposes, heshe can so indicate and include the justification.

1.1.4.2 The justification will be documented in the physician assessment of current patient condition.

1.2 The attending or on call physician provides an order authorizing restraints andor seclusion using the Physician's Orders Form (USH 44-0182), when the procedure is required. The order includes, but is not limited to:

1.2.1 Date and time;

1.2.2 Start time;

1.2.3 End time;

1.2.3.1 The physician specifies the duration of restraint andor seclusion within the following limits:

1.2.3.1.1Not to exceed one hour for patients under age 9

1.2.3.1.2Not to exceed two hours for patients ages 9 - 17

1.2.3.1.3Not to exceed four hours for patients ages 18 and older

1.2.3.2 If additional time is needed, a new order must be written and documentation must be made justifying its continued use.

1.2.4 Requirement(s) for the RN to release the patient early, when discontinuation criteria are met. (see 3.8.2.1).

1.2.5 The order for seclusion or restraint is contained on a label approved by medical records and gives detail of the type adn duration of seclusion or restraint.

1.3 Each patient secluded or restrained will have a face to face assessment by a physician within one hour of the initiation of seclusion or restraint.

1.3.1 The report of this assessment will include a description of the current condition of the patient.

1.4 At the time of the face to face assessment, the physician:

1.4.1 Works with the individual and staff to identify ways to help the individual regain control.

1.4.2 Makes any necessary revisions to the individual's treatment plan, and

1.4.3 If necessary, provides a new written order. This order and any subsequent orders follow the time-limits addressed in 1.2.3.1.

1.4.4 May determine that the use of this physical restraint is more

appropriately considered an application of a medical safety device.

1.4.4.1 If the physician determines that the application is a medical safety device, the physician documents the reason for this decision in the PIRS report. Medical protective device policy and procedures are followed.

1.5 The Seclusion and Restraint Incident is documented in the Patient Incident Reporting System (PIRS).

1.5.1 Documentation in PIRS is done by the nurse and physician involved.

1.5.2 Restraint options are: four point, full body net, physical hold, two-point, and wrist to waist.

1.5.3 The RN states in the PIRS report the specific behaviors or symptoms of the patient which necessitated seclusion and/or restraint.

1.6 An order for seclusion or restraint ends when the patient is released or when the time authorized expires, whichever comes first.

1.7 The attending psychiatrist or designee is contacted by the charge nurse when an original order for seclusion or restraint has expired and the individual may need to be continued in seclusion or restraint.

1.7.1 The psychiatrist follows the procedures set forth in 1.1, 1.2, 1.3, 1.4, and 1.5.

1.7.2 The psychiatrist conducts an in-person re-assessment of individuals maintained continuously in seclusion or restraint beyond specific time limits.

1.8 To assure that the attending psychiatrist is aware of every incident, upon return from any absence from the hospital, attending psychiatrists will review all incidents of restraint and seclusion which have occurred in their absence.

2. Hospital Clinical Director or designee and Clinical Safety Committee:

2.1 The Hospital Clinical Director or designee reviews all PIRS reports and investigate unusual or possibly unwarranted patterns.

2.2 Any death that occurs while a patient is restrained or in seclusion, or where it is reasonable to assume that a patient's death is a result of restraint or seclusion, the clinical director or designee reports to the Health Care Financing Administration (303.844.7048).

3. Administrator on call: The administrator on call is a clinical leader who is informed by nursing administration of incidents in which individuals experience extended, or multiple episodes of seclusion or restraint.

3.1 The administrator on call is immediately notified by the unit UND or SSRN of any instance in which an individual remains in restraint for more than 12 hours or experiences 2 or more separate episodes of seclusion or restraint within 12 hours.

3.2 The administrator on call assesses whether additional resources are required to facilitate discontinuation of restraint or seclusion.

4. Registered Nurse and Nursing Service:

4.1 All staff involved in the use of seclusion and/or restraint are appropriately trained and competencies are documented (see Nursing Manual).

4.2 A registered Nurse notifies the attending psychiatrist or the psychiatric officer of the day immediately regarding a patient who may need restraint and/or seclusion. Basic information regarding the patient is provided by the RN as specified in the nursing manual, "Notification of On-call Personnel" (Nursing Manual, Chapter 2: Patient Management).

4.3 In an emergency, while awaiting physician assessment, physical restraint or seclusion may be initiated under the direction of a registered nurse.

4.3.1 Whenever the use of seclusion or restraint is initiated by the RN under this provision, the RN contacts the attending psychiatrist or designee immediately so as to obtain an order to allow the psychiatrist time to perform the required in-person assessment within one hour.

4.4 Whenever the SSRN is on duty, the RN receiving the order for seclusion or restraint notifies the SSRN immediately.

4.5 The Patient Advocate is immediately notified of the use of seclusion and/or restraint.

4.6 If authorized by the patient and if family or guardian agrees, nursing staff promptly attempts to contact family to inform them of the initiation of seclusion and/or restraint.

4.6.1 Authorization by the patient does not apply for individuals under age 18.

4.7 A clinical assessment of the patient and the order for the use of emergency restraint and/or seclusion is documented in the patient record when the procedure is implemented. The RN entry in PIRS indicates the inadequacy of less restrictive interventions, such as items on the patient's deescalation form.

4.8 The Registered Nurse insures that restraint and/or seclusion is used in a manner that does not cause undue physical discomfort, harm, or pain, and documents any possible trauma resulting from the use of restraints.

4.9 Nursing staff assist patients in seclusion and restraints.

4.9.1 Staff continuously monitor patients in seclusion or restraint.

4.9.1.1 This monitoring is done in person by an assigned, trained staff member for the first hour of a seclusion or restraint episode.

4.9.1.2 After the first hour, patients in seclusion only may be monitored continuously by audio and visual equipment if the patient prefers or if in the unit charge nurse's judgement this would be consistent with the patient's condition.

4.9.1.3 Treatment unit staff provide a one-to-one watch for patients in restraints in order to protect them from possible harm by other patients. This is performed in person by a staff member in close visual proximity to the patient.

4.9.2 Nursing staff provide assistance to individuals in meeting criteria for discontinuation of restraint or seclusion.

4.9.2.1 Discontinuation criteria are:

4.9.2.1.1 Verbally calm, for example, cessation of threats; and

4.9.2.1.2 Physically calm, for example, pulse and respirations within normal range for this patient, not clenching jaw or fist; and

4.9.2.1.3 Engages with staff appropriately, for example, verbally contracts for safety, no longer angry when questioned about circumstances that led to the incident; and

4.9.2.1.4 Other criteria which may be specified in the physician's order.

4.9.2.2 Staff monitoring or assessing the individual in seclusion or restraint make the individual aware of the rationale for these interventions and the behavior criteria for their discontinuation.

4.9.2.3 The unit charge nurse discontinues seclusion or restraint as soon as discontinuation criteria are met.

4.9.3 Trained staff attend to the individual's physical needs and safety during seclusion and restraint.

4.9.3.1 Items to be addressed include taking and interpreting vital signs, nutrition and hydration needs, circulation and range of motion, hygiene and elimination, psychological status and comfort, reporting situations in which medical personnel should be contacted. (See 15 minute check debriefing window in PIRS).

4.10 Expiration of order for seclusion or restraint: If a person placed in seclusion or restraint remains in seclusion or restraint until the time of the order expires, the charge nurse conducts an in-person re-evaluation.

4.10.1 In conjunction with the re-evaluation, if the restraint or seclusion must be continued, a new written or verbal order is obtained from the attending psychiatrist or designee.

4.10.1.1 The time limits for continued orders are the same as in 1.2.3.1.

4.10.2 The charge nurse re-evaluates the efficacy of the individual's treatment plan and works with the individual to identify ways to help him/her regain control.

4.11 Unit charge nurse, and a patient advocate when available, debrief the patient after an incident of seclusion or restraint.

4.11.1 The debriefing includes the patient's family when appropriate.

4.11.2 The debriefing occurs on the shift in which the seclusion or restraint is discontinued, using the designated form.

4.11.2.1 If the patient has fallen asleep by the time of discontinuation, the unit charge nurse documents this and arranges for the patient to be debriefed upon awakening.

4.11.3 The debriefing addresses what led to the incident and what could have been handled differently.

4.11.4 The debriefing is used to ascertain that the individuals physical well being, psychological comfort, and right to privacy were addressed.

4.11.5 The debriefing arranges for counsel to be provided to the individual for any trauma that may have resulted from the incident.

4.11.6 When indicated, modification to the treatment plan is made.

5. New orders: Each application of seclusion or restraint requires a new order and a physician assessment within one hour of initiation.

6. Responsibilities of Unit Clinical Directors, Unit Nursing Directors, and Shift Supervisors:

6.1 Unit Clinical Directors, Unit Nursing Directors, and Shift Supervisors have oversight of clinical responsibilities to monitor the appropriate use and documentation of restraints and seclusion.

6.2 Unit leadership meets within a week of each use of seclusion or restraint to review each incident and make appropriate changes to structure, programming, or treatment plans if indicated in an attempt to avoid further seclusion and/or restraint events.

6.2.1 Unit leadership use patient debriefing information in reviewing incidents.

Implemented: 3-25-83

Revised: 3-13-86

Revised: 3-25-88

Revised: 12-13-90

Reviewed: 4-92

Revised: 2-95

Reviewed: 9-95

Revised: 3-96

Revised: 8-97

Revised: 4-00

Revised: 1-01

Revised: 5-03

Revised: 7-03

Revised: 8-03

Revised: 5-04

Chapter: ^{lxxxii} Special Treatment Procedures (SP)

Section 3: Defusing

Policy

Defusing sessions are held at the hospital following psychiatric emergencies or following other serious incidents, which are traumatic or may be potentially traumatizing to staff.

Definitions

Psychiatric Emergency: Any incident involving seclusion, restraint, or violence which may be traumatizing.

Defusing: A meeting of direct care staff involved in a violent event with a member of the unit SMT or Executive Staff. It is held shortly after a psychiatric emergency occurs and is intended to help the staff begin to cope with their stress and return to effective service.

Procedure

1. When a psychiatric emergency occurs at the hospital during regular business hours, the charge RN supervising the staff involved in the incident immediately contacts the UND (or another member of the SMT).
 - 1.1 After regular business hours (0800-1700) the charge RN notifies the SSRN of such an event immediately following the event.
2. During business hours, the Unit AD conducts a defusing session with the staff members involved in the incident before the end of the shift.
 - 2.1 The SMT or hospital administration may request the assistance of non-unit managers to assist with this process is deemed appropriate.
 - 2.2 If a defusing cannot be held with the staff members involved before they leave shift, the SMT will follow up with that employee(s).
3. After business hours, the SSRN contacts the Administrator On-Call (AOD) to review the incident and determine the need to initiate a defusing session.
 - 3.1 The SSRN, whenever possible, assists the AOD in conducting the defusing

session.

4. Hospital administration and unit SMT members follow up with employees regarding identified needs for EAP, further administrative support, etc.

Implemented: 3-04

Chapter: lxxxiii Special Treatment Procedures (SP)

Section 4: Incident Reviews of Seclusion and Restraint Events

Policy

Each seclusion or restraint episode is reviewed at the unit and hospital levels so that the improvement of quality care facilitated.

Procedure

1. Within five days of a seclusion or restraint event, the unit AD or designee holds an incident review meeting to discover what may be learned from the incident and to establish a plan of action.

1.1 The patient is invited to attend and participate, unless the attending psychiatrist indicates it would be counter productive to do so.

1.2 Others invited are a patient advocate, SMT (Service Management Team) members, the direct care staff involved, security staff involved, SSRN involved, a member of the hospital executive staff, and a person to take minutes.

1.3 Quality Resource staff may be asked for consultation in root cause analysis procedures, applicable to JCAHO standards and CMS regulations.

1.4 The AD considers the following questions items for the review agenda:

1.4.1 What occurred from each participant's perspective, and what are their feelings?

1.4.2 Is anyone traumatized by this event and in need of trauma care?

1.4.3 What went well and not so well?

1.4.4 Were there any power struggles involved?

1.4.5 How were deescalation preferences accessed by staff and applied?

1.4.6 Are there "systems issues" such as level of staffing and staff

competence, supervision, environment of care, and need for change of policy/procedures?

1.4.7 Is there a need for a change in the treatment plan?

1.4.8 What is the plan of action? Who gets what assignments, and when will this be followed-up in SMT meeting?

2. Within a few weeks of the incident, the incident is reviewed in an SMT meeting and followed-up.

2.1 The plan of action is reviewed and further plans/assignments made, as needed.

2.2 A copy of the SMT meeting minutes is highlighted for incident review content and forwarded to the hospital executive staff for further review and follow up.

3. The executive staff aggregates hospital wide incident information and makes hospital-level improvements, as indicated.

Implemented: 7-04

Chapter: ^{lxxxiv} Special Treatment Procedures (SP)

Section 5: Aversive Treatment

Policy

Utah State Hospital prohibits behavior modification procedures that use aversive conditioning.

Procedure

1. Utah State Hospital employees are trained in patient rights which prohibit aversive behavior modification treatment.
 - 1.1 Aversive treatment includes, but is not limited to, the following:
 - 1.1.1 Any act or practice that may result in the denial of a nutritionally adequate diet. (TX.M.6.5.7)
 - 1.1.2 Corporal punishment. (TX.M.6.5.6)
 - 1.1.3 Fear-eliciting acts. (TX.M.6.5.7)
 - 1.1.3.1 Fear-eliciting acts are those used to intentionally elicit a fear-type response.
 - 1.1.4 Any other act, procedure, or treatment, which is deemed aversive by the Hospital Clinical Director or Hospital Ethics Committee.
2. The unit psychiatrist approves specific behavior management procedures which are documented in the patient's individual treatment plan.
3. Treatment teams may refer any question as to whether treatment is aversive to the Hospital Behavior Management Committee and/or Ethics Committee.
4. If a disagreement occurs between the Hospital Behavior Management Committee and a treatment team, the issue is then reviewed by the Hospital Ethics Committee.

*Implemented: 9-16-83
Reviewed: 3-13-86
Revised: 8-22-88*

Revised: 5-25-89

Reviewed: 1-91

Reviewed: 2-92

Revised: 8-95

Revised: 1-96

Revised: 6-98

Reviewed: 12-00

Chapter: ^{lxxxv} Special Treatment Procedures (SP)

Section 6: Research Involving Inconvenience or Risk to the Patient

Policy

Research projects that involve inconvenience or risk to the patient require close attention to the rights of patients and must meet established procedures and guidelines.

Procedure

1. The clinician authorized by the hospital research committee obtains the written informed consent of the patient who will participate in the research project. The consent is included in the patient's record. The patient may withdraw consent at any time.

1.1 When required, the written informed consent of the family and/or legal guardian is obtained and made part of the patient's record. The family and/or guardian may withdraw consent at any time.

1.2 In cases dealing with children or adolescents, the responsible parent(s), relative, or guardian, and, when appropriate, the patient gives written, dated, and signed informed consent. The family and/or guardian and, when appropriate, the child or adolescent patient may withdraw consent at any time.

2. The attending physician states in the patient's record the rationale for research that involves inconvenience or risk to the patient.

3. The research committee reviews research procedures that involve inconvenience or risk to the patient prior to implementation and reports findings to the Hospital Clinical Director.

4. The attending physician documents in the patient's record the clinical indications for the use of research procedures that involve inconvenience or risk to the patient.

5. The research committee assures that the clinical indications for the use of research procedures that involve inconvenience or risk to the patient outweigh the known contra-indications.

Reviewed: 3-13-86

Revised: 3-25-88

Reviewed: 1-91

Reviewed: 2-92

Reviewed: 9-95

Reviewed: 6-98

Revised: 9-01

Chapter: ^{lxxxvi} Special Treatment Procedures (SP) Section 7: Levels of Suicide Precautions

Policy

1. The use of levels of suicide precautions for patients at Utah State Hospital requires clinical justification and is employed only to prevent a patient from harming him/herself. Suicide precautions are not used as punishment or for the convenience of staff. The rationale for the use of suicide precautions addresses the inadequacy of less restrictive intervention techniques.
2. The levels of suicide precautions described in this policy statement are for use throughout Utah State Hospital. Because they involve a restriction on an individual's freedom, a physician's order is required to move a patient from one level to another level. A registered nurse may increase the level of observation in emergency situations prior to obtaining a doctor's order.

Procedure

1. Attending Psychiatrist:
 - 1.1 Completes a clinical assessment of the patient to ascertain that the suicide precaution level is justified.
 - 1.2 Authorizes suicide precautions using the Doctor's Order form (USH 44-0182) at the time the procedure is implemented.
 - 1.3 Writes a progress note with a description of the condition of the patient and the reason for authorizing suicide precautions at the time the procedure is implemented or as soon thereafter as is practical, not to exceed 24 hours. The progress note addresses the inadequacy of less restrictive intervention techniques, *i.e.*, medication, staff and/or peer one-to-one contact, time-out, area restriction, and the seriousness of the suicide attempt/plan.
 - 1.4 Specifies the level of suicide precautions and evaluates the order on at least a weekly basis with staff input.
 - 1.5 In an emergency may verbally (by phone) give a suicide-level order to a registered nurse.

2. Psychiatric Officer of the Day:
 - 2.1 Is responsible for authorizing orders for levels of suicide precautions when indicated during his/her tour of duty.
 - 2.2 In an emergency may verbally (by phone) give a suicide level order to an RN.
3. Nursing Service (RNs):
 - 3.1 Notifies the attending psychiatrist or psychiatric Officer of the Day immediately regarding a disturbed patient who may need initiation of suicide precautions or whose condition warrants a change in level.
 - 3.2 In an emergency, initiation of suicide precautions may be utilized by a registered nurse. The emergency utilization of suicide precautions may also include moving a patient to a more restrictive level based on the registered nurse's judgment. The registered nurse obtains a psychiatrist's order for the suicide precautions as soon as possible. A less restrictive level may be utilized by RN after treatment staff's evaluation. RN obtains a physician's order for less restrictive levels and documents in progress notes rationale for level change.
 - 3.3 A clinical assessment of the patient and the order for the suicide precautions is documented in the patient record when the procedure is implemented. When a registered nurse is the initiator of the suicide precautions, a progress note is written by the registered nurse and placed in the patient's chart. The progress note addresses the inadequacy of less restrictive intervention techniques.
 - 3.4 Nursing Service records the use of the levels of suicide precautions in the manner described for each level.
 - 3.5 Nursing Service assists in returning the patient to the unit routine as soon as possible.
4. Suicide Precautions Level I (One-to-one):
 - 4.1 Criteria: Those patients with suicidal ideation or delusions of self-mutilation who, after assessment by the unit staff, present clinical symptoms that suggest a clear intent to follow through with the plan or delusion.
 - 4.2 Examples of patient symptoms: The patient who is currently verbalizing a clear intent and/or plan to harm self; the patient who is unwilling to make a no-suicide contract; the patient with poor impulse control with intent to harm him/herself; the patient who has attempted suicide in the last week by a particularly lethal method, e.g., hanging, gunshot, or carbon monoxide.
 - 4.3 Nursing Care: One-to-one continuous nursing observation or restraints with continuous nursing observation always within line of sight in a designated area and within a length (or distance) specified (or designated) by the physician and interaction 24 hours a day. Nursing assessment and documentation completed on every shift by a registered nurse; restriction to the ward.
5. Suicide Precautions Level II (Direct observation status (DOS)):
 - 5.1 Criteria: Those patients with suicidal ideation and who, after assessment by the treatment team, present clinical symptoms that indicate a higher suicide

potential than Level III.

5.2 Examples of patient symptoms: The patient with a concrete suicide plan, the patient who is ambivalent about making a no-suicide contract, the patient who has limited impulse control with intent of self-harm, the patient with a suicide attempt or gesture within the recent past.

5.3 Nursing Care: Continuous nursing observation in line of sight in a designated area and interaction 24 hours a day, nursing assessment and documentation completed on every shift by a registered nurse, restriction to the ward.

6. Suicide Precautions Level III (Fifteen minute checks):

6.1 Criteria: Those patients who have suicidal ideations and how, after assessment by the treatment team, are assessed to be in minimal danger of actively attempting suicide.

6.2 Examples of patient symptoms: The patient with vague suicidal ideation but without a plan, the patient who is willing to make a no-suicide contract, the patient with insight into existing problems, the patient with a previous history of suicide (may have made an attempt within the last thirty days).

6.3 Nursing Care: Check patient's whereabouts every fifteen minutes 24 hours a day, frequent verbal interactions during waking hours, nursing assessment and documentation completed on an every-shift basis by a registered nurse, restriction to the unit.

Implemented: 8-5-88

Reviewed: 1-91

Reviewed: 2-92

Revised: 12-93

Reviewed: 9-95

Revised: 12-98

Revised: 2-00

Chapter: ^{lxxxvii} Special Treatment Procedures (SP)

Section 8: Medication of Adult Patients

Policy

Adult patients (18 years and older) residing at the Utah State Hospital are entitled to certain due process proceedings prior to being administered medication treatment against their will. The intent of this policy is to balance the interests of the patient in freedom from unnecessary bodily intrusions against the legitimate governmental interests of the Utah State Hospital that are incidental to the basis of the legal institutionalization of the particular patient.

Individuals to Whom This Policy Applies

This policy applies to adult (18 years and older) patients committed to a local mental health authority pursuant to a court order of civil commitment (UCA 62A-12-234), patients committed as Not Competent to Proceed (UCA 77-15-6), patients committed for purposes of Evaluation in connection with a criminal proceeding (Title 77), patients committed as Guilty and Mentally Ill (Title 77, Chapter 16a), patients committed as Not Guilty by Reason of Insanity (UCA 77-16a-302), Voluntary patients (62A-12-228), and any other legal status by which a patient may be committed and who then resides at the Utah State Hospital.

Summary of Policies

An adult patient may be treated with medications, including psychoactive medications when, as provided within this policy, any one or more of the following conditions exist:

1. The patient or legal guardian gives informed consent.
2. The patient or legal guardian does not consent, but the Medication Hearing Committee decides that such is an appropriate medical treatment.
3. The medication is necessary in order to control the patient's dangerous behavior and is administered for an exigent circumstance in accordance with the policies listed

below.

4. The patient arrives at the Utah State Hospital already under medication and the treating physician continues such medication, but only temporarily and under limited conditions in accordance with the policies listed below.

Policy

A. PROCEDURES FOR CONSENT

Many patients are capable of making informed decisions concerning medication treatment; therefore, it is necessary for the physician to assess the patient's ability to make such informed decisions--that is, whether the patient is able to give "informed consent."

1. In order to assess the patient's ability to give informed consent, the physician must explore the adequacy of information given to the patient, the patient's comprehension of that information, and the patient's ability to voluntarily participate in a treatment program. Determination of these issues is resolved in a clinical setting by applying the following four basic tests:

1.1 Does the patient recognize the nature of his or her condition? (Does the patient believe that he or she is ill and does the patient have a reasonably good understanding of the nature of his or her condition?)

1.2 Does the patient have an understanding of the proposed treatment and any alternative options to treatment which may exist (including no treatment), particularly with respect to the potential benefits and side effects of each alternative?

1.3 Is the patient able to discuss the options with some degree of understanding (i.e., the patient exhibits more understanding than a mere rote recitation of the information provided)?

1.4 Is the patient able to give a description of how he or she reached a conclusion with respect to consenting to psychoactive medication treatment?

2. This determination is decided once the treating physician has presented the patient with a completed *Proposed Medication Treatment Information* form, which includes the following information:

2.1 the patient's diagnosis;

2.2 the recommended medication treatment, the method of administration;

2.3 the desired beneficial effects of the patient's mental illness as a result of the recommended treatment;

2.4 the possible and/or probable mental health consequences to the patient if the recommended treatment is not administered;

2.5 the possible side-effects, if any, of the recommended treatment; and

2.6 the right to give or withhold consent for the proposed treatment.

2.6.1 When informing a patient of his or her right to withhold consent, the patient must also be informed of the hospital's right to initiate a medication hearing and have a committee determine whether the proposed treatment is necessary.

3. If it is determined that the patient is able to give informed consent and the patient wishes to do so, a *Consent to Medication Treatment* form is completed and filed in the medical record. A copy is provided to the Legal Services Office.

3.1 A patient may revoke his/her consent to medication treatment at any time by informing the staff and/or signing a *Notice of Revocation* form.

4. If the patient is able to give consent but refuses to do so, or is not able to give consent, the staff may initiate a Medication Hearing in accordance with part "D" of this policy.

B. MEDICATION TREATMENT IN EXIGENT CIRCUMSTANCES

1. A patient may be involuntarily treated, including treatment with medication for a mental disorder under emergency circumstances when a qualified physician has determined the patient is likely to cause injury to him/herself or to others if not immediately treated.

2. The treating physician certifies that he or she is of the opinion that the patient is likely to cause injury to him/herself or others if not immediately treated. The certification is documented in the Physician's Orders section of the working chart.

2.1 Involuntary treatment in exigent circumstances may be continued for a maximum of 24 hours, excluding Saturdays, Sundays, and legal holidays. At the expiration of that time period, the patient is not involuntarily treated unless a "Notice to Convene a Medication Hearing" form has been prepared and provided to the patient pursuant to the provisions of this policy. If, at any time, the treating physician determines that medication is no longer necessary, the medication is discontinued.

C. PATIENTS ARRIVING AT USH ALREADY UNDER MEDICATION TREATMENT

1. When a patient is admitted to USH and is already receiving medication treatment, the admitting physician certifies that continuing such treatment is appropriate only if the following conditions are met:

1.1 The patient is gravely disabled and in need of continuing the medication treatment because the patient suffers from a mental illness such that the patient:

1.1.1 Is in danger of serious harm resulting from a deficiency of essential human needs of health or safety; or

1.1.2 Without medication treatment the patient would manifest severe deterioration in routine functioning evidenced by repeated and/or escalating loss of cognitive or volitional control over his/her actions and, without the continuation of such treatment, the patient will not be receiving such as is essential for his/her health or safety; or

1.1.3 Without continuing the medication treatment, the patient would pose a likelihood of serious harm to the patient, others, or their property.

2. The basis for the treating physician's decision is supported by adequate documentation and is demonstrated by the physician completing and signing the Initial Psychiatric Assessment form.

3. Within a reasonable time after admission and not exceeding 14 days, the attending physician should propose a new or continuing medication treatment, if

appropriate.

3.1 In making the decision to administer or consider medication, the physician considers the patient's medical interests and needs and the purpose for which the patient is being treated.

D. INITIATING A MEDICATION HEARING

1. If a patient is able to give informed consent to medication treatment, but refuses to do so, or if the patient is unable to give consent, the treating physician may request a Medication Hearing be held to determine if medication treatment is necessary.
2. The treating physician completes a *Request to Convene a Medication Hearing* form and submits the form to the Utah State Hospital Legal Services Office. Except for medication that is administered pursuant to the policy dealing with Exigent Circumstances or Treatment of Patients Who Arrive Already Receiving Medication, no involuntary treatment occurs prior to the patient being afforded a hearing with a decision on that hearing in accordance with the procedures outlined in this section.
3. The USH Legal Services Managerdesignee contacts committee members and sets a date and time for the hearing. The Legal Services Managerdesignee forwards a *Notice to Convene a Medication Hearing* form to the attending physician for completion which advises the patient of the tentative diagnosis, the factual basis for the diagnosis, and why the treating physician believes medication treatment is necessary. The patient receives a copy of the notice at least 24 hours prior to the scheduled hearing.
4. The hearing is held within a reasonable time after notice has been given to the patient. If the patient refuses to attend the hearing or otherwise waives his/her right to attend the hearing, the hearing is held in the absence of the patient. The patient's absence from the hearing does not alter the decision reached with respect to whether or not to proceed with the proposed course of treatment.
5. Prior to the hearing, the treating physician provides to the Hearing Committee documentation regarding the patient's mental condition, including the patient's medical records, doctor's orders, nursing notes, and any other documents available which are pertinent to the determination of whether to proceed with the proposed course of treatment. The patient has the right to examine these documents unless it is determined that releasing the information contained in certain documents, or portions thereof, would be detrimental to the patient's health or to the safety of any individual. (See Utah Code Annotated 63-2-404(2)(a))

E. THE MEDICATION HEARING COMMITTEE

1. Medication hearings are conducted before a three-member committee consisting of at least one psychiatrist and one non-physician. The third member may be from any professional hospital discipline (RN, LCSW, Psychologist, MD, etc.)
2. At the time of the hearing, the committee members are not involved in the patient's present treatment or diagnosis. Committee members who have treated or diagnosed the patient in the past, but are not currently involved in the patient's treatment, are not disqualified from participation.
3. The role of the Committee is to render a decision regarding a medical issue. The members review the patient's medical records, review information presented at the hearing, and render a decision based upon the information and documentation provided.

3.1 The rules of evidence are not applicable.

F. THE MEDICATION HEARING

1. Medication hearings are conducted on the treatment units and are conducted in an informal, non-adversarial manner so as not to have a harmful effect upon the patient.

2. The patient has the following rights at the hearing: (1) to attend the hearing; (2) to present evidence on his/her behalf; (3) to call witnesses; and (4) to question witnesses called by committee members. Because the issue before the committee is purely medical in nature, neither the treating physician nor the patient has the right to legal representation at the hearing. If the patient so chooses, he/she may be represented by a lay advisor who understands the psychiatric issues involved, but the lay advisor need not be provided at government expense.

2.1 If the patient has a previously appointed legal guardian, the legal guardian should be notified of the hearing and be permitted to attend the hearing.

3. One committee member chairs the committee and conducts the hearing. The chair begins each hearing by informing the patient and others present of the purpose of the hearing and the manner in which the hearing will proceed.

4. The treating physician attends the hearing and presents the physician's findings and recommendations with respect to the patient's treatment. The committee members and the patient or the patient's lay advisor may question the treating physician.

5. Other staff members may present information. The committee members and the patient or the patient's lay advisor may question staff members who present information.

6. The patient has the right to present information, which may include witnesses. The committee members have the right to question any witnesses called by the patient.

7. If the patient or others become disruptive during the hearing, the chair may warn that person that he/she will be removed from the hearing unless the disruptive behavior is discontinued. If the disruptive behavior continues, the chair may have that person removed. In the event that the patient or others are removed, the hearing continues in that person's absence.

8. Following the presentation of information, the patient, the treating psychiatrist, and others leave the room while the committee deliberates. Upon reaching a decision, the patient and others are permitted to return to the room to hear the committee's decision.

G. REQUIRED CRITERIA FOR MEDICATING AN ADULT PATIENT

1. The committee may order medication treatment of a Civilly Committed, Voluntary, Court Ordered Evaluation, Not Guilty by Reason of Insanity, Guilty and Mentally Ill, and any other criminal status (excluding Not Competent to Proceed) patient if, after consideration of the record and deliberation, the committee's psychiatrist and at least one other member find, by majority vote, the following conditions exist:

1.1 The patient suffers from a mental illness as found in the current edition of the DSM; and

1.2 The patient is, or will be, gravely disabled and in need of medication treatment or continuing medication treatment for the reason that he or she suffers from a mental disorder such that he or she (a) is in or will be in danger of serious physical harm resulting from a failure to provide for his or her essential needs of

health or safety, or (b) manifests, or will manifest severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety; and/or

1.3 Without medication treatment or continuing medication treatment, he or she poses or will pose a likelihood of serious harm to himself/herself, others, or their property. "Likelihood of serious harm" means either (a) a substantial risk that physical harm will be inflicted by an individual upon his/her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on himself/herself, or (b) a substantial risk that physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which has placed another person or persons in reasonable fear of sustaining such harm, or (c) a substantial risk that physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; and

1.4 The proposed medication treatment is in the medical best interest of the patient, taking into account the possible side effects as well as the potential benefits of the treatment; and

1.5 The proposed medication treatment is in accordance with prevailing standards of accepted medical practice.

2. The committee may order medication treatment of a Not Competent to Proceed patient if, after consideration of the record and deliberation, the committee's psychiatrist and at least one other member finds, by majority vote, the following conditions exist:

2.1 The treatment, which may include treatment with psychoactive medication(s), is medically appropriate and, considering less intrusive alternatives, essential for the sake of the patient's safety or the safety of others; or

2.2 The treatment, which may include treatment with psychoactive medication(s), is medically appropriate in order to restore the patient to a state of competency so that criminal charges pending against the patient can be adjudicated and that competency cannot be restored within a reasonable period of time by using less intrusive means.

3. The basis for the decision is supported by adequate documentation. The psychiatrist on the committee must be in majority in any decision to medicate a patient.

3.1 In the event that two psychiatrists sit on the committee and disagree whether to medicate a patient, the matter is referred to the Hospital Clinical Director for a decision.

4. The committee members complete and sign a Medication Hearing form at the end of the hearing. A copy is provided to the patient.

5. Minutes of the hearing are kept and a copy is provided to the patient upon request.

H. RIGHT TO APPEAL

1. The patient has the right to appeal the committee's decision to the Hospital Clinical Director/designee by completing an Appeal of Medication Hearing form within 24 hours (excluding Saturdays, Sundays, and Legal Holidays) of being informed of the decision. The Hospital Patient Advocate or treatment coordinator may assist the patient

in completing the form.

1.1 The Hospital Clinical Directordesinee reviews the record available and renders a decision within 48 hours of receipt of the appeal. The Hospital Clinical Directordesinee completes and signs a Decision of Appeal of Medication Hearing form which is provided to the patient.

2. Medication treatment ordered by the Committee may be commenced within 24 hours of the Committee's decision if no appeal is taken. If an appeal is taken, medication treatment may be commenced as soon as the Hospital Clinical Directordesinee renders his/her decision if he/she agrees with the committee's decision.

I. CONTINUED MEDICATION TREATMENT

1. Medication treatment ordered pursuant to the foregoing procedures may continue with periodic review after the initial hearing.

2. The Hospital Clinical Directordesinee reviews the case within 180 days of the initial hearing.

3. The Hospital Clinical Directordesinee reviews the record and may examine the patient if further clinical information is necessary before rendering a decision whether to continue medication treatment.

4. The Hospital Clinical Directordesinee may order continued medication treatment of a Civilly Committed, Voluntary, Court Ordered Evaluation, Not Guilty by Reason of Insanity, Guilty and Mentally Ill, and any other criminal status (excluding Not Competent to Proceed) patient if he/she finds the following conditions exist:

4.1 The patient continues to suffer from a mental illness as found in the current edition of the DSM; and

4.2 Absent continued medication treatment, the patient will experience deterioration making him/her gravely disabled such that he/she (a) will be in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety, or (b) will manifest severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety; and/or

4.3 Absent continued medication treatment, he or she will pose a likelihood of serious harm to himself/herself, others, or their property. "Likelihood of serious harm" means either (a) a substantial risk that physical harm will be inflicted by an individual upon his/her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on one's own self, or (b) a substantial risk that physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which has placed another person or persons in reasonable fear of sustaining such harm, or (c) a substantial risk that physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; and

4.4 The medication treatment is in the medical best interest of the patient, taking into account the possible side effects as well as the potential benefits of the treatment; and

- 4.5 The medication treatment is in accordance with prevailing standards of accepted medical practice.
5. The Hospital Clinical Director/designee may order continued medication treatment of a Not Competent to Proceed patient if he/she finds the following conditions exist:
- 5.1 The treatment, which may include treatment with psychoactive medication(s), is medically appropriate and, considering less intrusive alternatives, essential for the sake of the patient's own safety or the safety of others; or
- 5.2 The treatment, which may include treatment with psychoactive medication(s), is medically appropriate in order to restore the patient to a state of competency so that criminal charges pending against the patient can be adjudicated and that competency cannot be restored within a reasonable period of time by using less intrusive means.
6. If the Hospital Clinical Director/designee approved continued medication treatment, he/she completes a Review of Continued Medication form, which is placed in the patient's medical record. A copy is provided to the Legal Services Office.
- 6.1 The treating physician then reviews the case and writes a progress note in the patient's chart every thirty days while the adopted course of medication continues.
7. At the end of 12 months, the case is again reviewed by the Hospital Clinical Director/designee as outlined in part I.
8. If the procedures for medication hearing result in a finding that the patient does not meet the standards to be medicated, the hospital may consider the individual not appropriate for treatment at the hospital.

Implemented: 12-92

Revised: 5-92

Revised: 3-25-93

Revised: 5-93

Revised: 7-94

Implemented: 1-95

Reviewed: 9-95

Revised: 10-96

Reviewed: 7-98

Reviewed: 12-00

Revised: 11-01

Chapter: ^{lxxxviii} Special Treatment Procedures (SP)

Section 9: Restrictions and Limitations of Patient Rights

Policy

Utah State Hospital upholds and protects the civil rights of patients in its care. Restrictions and/or limitations are implemented only for "good cause" reasons and are reviewed periodically for therapeutic effectiveness.

Definitions

Good Cause means (1) it poses a danger to self or others; (2) it would seriously infringe on the rights of others; (3) it would pose serious damage to the facility; and/or (4) it is deemed therapeutically contraindicated.

Temporary Restriction means the restriction or limitation is time-limited and refers to all restrictions of patient rights as outlined in the Patient Rights Booklet (i.e. phone calls, visits, mail, privacy).

Ongoing Restriction means all other restrictions for the duration of the patient's hospitalization.

Procedure

1. When any right of a patient is limited or denied, the nature, extent, and reason for that limitation is documented in the medical record and explained to the patient. (UCA 62A-12-245(2))
2. Restriction may be initiated by the clinical staff if it is determined that such restrictions are necessary for the safety of self or others and for "good cause."
 - 2.1 Restrictions may include, but are not limited to: visitors, mail, telephone calls.
3. Restrictions are implemented with a physician's order.
 - 3.1 Entries are made in the progress notes and physician orders sections of the medical record.
4. All such restrictions on visitors, mail, telephone calls, and other forms of communication are fully explained and determined with the participation of the patient/family, upon request.
 - 4.1 The term "patient/family" takes into consideration the patient's right to exercise personal privacy by withholding consent for family or significant other's

participation.

5. Temporary restrictions are time-limited to seven days and are evaluated every seven days by the treating physician or designee for therapeutic effectiveness.

5.1 Rationale for temporary restrictions are documented in the progress notes corresponding to the physician's order.

6 Ongoing restrictions must be addressed in the monthly progress notes and be evaluated for continuation in the doctor's monthly progress notes.

7. In no case may a patient be denied a visit with or phone call to the legal counsel or clergy of the patient's choice. (UCA 62A-12-245(3))

7.1 If a visit is delayed, the reason justifying the delay must be documented

Implemented: 9-95

Revised: 1-96

Revised: 11-98

Reviewed: 12-00

Chapter: ^{lxxxix} Special Treatment Procedures (SP)

Section 10: Safety Intervention Techniques Training

Policy

USH provides Safety Intervention Training to employees to enable staff to manage violent behavior or behavior that presents imminent danger.

Procedure

1. All clinical and direct patient care staff members are trained in Safety Intervention Techniques (SIT).
 - 1.1 Employees are required to attend mandatory follow-up training bi-annually.
2. All USH staff are required to attend a verbal techniques training as part of mandatory training.
3. SIT training emphasizes the theories of verbal intervention and escape techniques as outlined in the SIT manual.
 - 3.1 Physical intervention is used **only** as a last resort and only by personnel trained in hospital approved techniques.
4. Trained staff members only use techniques explained in the SIT manual.
5. Approved wrist lock holds are used **only** by security staff. (Exceptions when a staff can use a wrist lock are outlined in SIT which would include hair pulls, life saving measures, and when a patient has a weapon).
 - 5.1 This technique is not used on the Geriatric unit.
 - 5.2 This technique may be used only on larger patients on the children's and adolescent units.
6. When Security personnel arrive on the scene, they guide the staff through the process of implementing safety technique procedures based on their training and expertise in handling security issues.
7. Physical restraint is initiated only when the nurse in charge determines that less aggressive interventions are inadequate for the safety of the patient, staff, and/or others.
8. The RN is accountable for all situations that occur on the unit and is responsible to make or delegate decisions regarding the use of safety intervention techniques.
9. Personnel involved in an incident which requires safety intervention techniques

document the incident on the Patient Incident Reporting System (PIRS), Progress Notes, and service area reports required by their respective service administrators.

9.1 Such documentation includes a description of the incident and the types of intervention used and which personnel used the techniques.

Initiated: 6-13-95
Revised: 8-96
Revised: 11-98
Revised: 6-03
Revised: 2-04

Chapter: Special Treatment Procedures (SP)^{xc}

Section 11: Secondary Prevention of Violence - Judiciously Suspending a Rule

Policy

Staff use their judgement for the purpose of preventing and minimizing violence by the charge nurse judiciously suspending a rule when doing so would lessen the possibility of immediate violence. This does not apply to elements of the conduct disorder track for pediatric patients.

Definitions

Rule: A practice or expectation for conduct, written or unwritten.

Procedure

1. Staff are encouraged to take all reasonable steps to prevent or minimize an imminent violent episode.
 - 1.1 When a patient is becoming increasingly agitated over a rule or community expectation, staff are encouraged to temporarily suspend that rule or control procedure, if the suspension will not obviously create an immediately more dangerous situation. (Examples of rules that may be subject to suspension include the manner and times that specific activities take place, and who is involved in these activities).
 - 1.2 When a conflict occurs the staff actively pursues options which will allow the patient to save face without creating an immediate danger to any person.
2. When staff see the need to suspend a rule, they make the recommendation to the charge nurse. The charge nurse may suspend the rule, and communicates this to the staff involved. The nurse then documents the suspension for the treatment team to review.
3. At the next regular treatment team meeting the rule suspension is reviewed and assignments are made to process the suspension with the patient and other individuals affected.
4. The SMT reviews significant rule suspensions as an agenda item in their weekly SMT meetings and documents the outcomes, decisions made, and further plans recommendations in their SMT minutes.
 - 4.1 A copy of the minutes is forwarded to the assistant clinical director.

Initiated: 3-04

Chapter: Special Treatment Procedures (SP)^{xci}

Section 12: Helping Patients Manage Violent Feelings - Use of Deescalation Information

Policy

Patients are assisted to attain control when becoming upset by staff offering calming techniques which are pre-identified by the patients or significant others. Staff also assist patients to avoid stressful experiences which may trigger aggressive responses towards self and/or others.

Procedure

1. At the time of admission and periodically thereafter, patients and/or their significant others are asked for their preference as to how they would like staff to assist them in achieving control when they are becoming upset.
 - 1.1 Charge nurses assign staff at the time of admission and as clinically indicated to meet with each patient and obtain information called for on the deescalation form.
 - 1.1.1 These assignments are made and completed prior to the treatment planning meeting.
 - 1.1.2 Individuals that have been identified as becoming aggressive towards self or others have a monthly review of their preferences to deescalate.
 - 1.2 The RN on duty at the time of the clinical brings this information into ICTP meeting for incorporation into the treatment plan.
2. UND's maintain a method on their units of keeping deescalation information readily available to direct care staff so that it may be immediately accessed when a patient is becoming stressed.
 - 2.1 Examples of effective methods are: keeping copies of these completed forms in a centrally located binder, or handing out a sheet of suggested methods for individual patients at the start of each shift.
3. As a patient is becoming upset, direct care staff review these preference and employs them to assist the patient to be in control of his/her behaviors.
4. As knowledge is increased about what works with each patient, this is recorded and shared.
 - 4.1 At the time of the unit incident reviews and ICTP reviews, the UND or

designee adds information to deescalation forms, indicating what methods have been successful and what triggers to avoid.

Initiated: 3-04

Chapter: ^{xcii} Technology Services (TS)

Section 1: Technology Services Office

Policy

The Technology Services Office provides Management and oversight of the Information Technology resources of the Utah State Hospital (USH). Services provided include Network Administration, Technical Support Services, and Application Program Development. Services are provided for units, disciplines, and offices within the Hospital. Technical assistance and consultation may also be provided to other organizations if determined to be in support of the USH mission.

Procedure

1. STAFFING

The Technology Services Office is staffed by an IT Manager, Network Operations Manager, two LAN Administrators, part time Development Manager, three full time application developers, and one Information Analyst (247 help desk support and training on E-chart and E-staff).

2. SERVICE AND SUPPORT

The Technology Services Office is open from 0800 hours to 1700 hours Monday through Friday, except holidays. The USH production networks and supported systems are available 24 hours per day except for the weekly maintenance downtime scheduled every Friday morning from 4:30 a.m. to 7:30 a.m. to request services, an employee may:

- 2.1 Visit the computer services office in the Heninger and MS buildings.
- 2.2 Contact the Network Support Help Desk at 44270. The Network Support Help desk is available during regular business hours. If the Help Desk is unattended, a brief description of request and/or problem, along with name, work location, and a number where you can be reached, can be left on the answering service. Calls for assistance will be responded to on the next business day.
- 2.3 Contact the E-chart Help Desk at 44676. The E-chart Help Desk is covered 24 hours per day. Employee's who need assistance with the use of E-chart can contact the help desk for immediate support on all

shifts. If the support person is helping another customer, please leave a voice message, and your call will be returned immediately.

2.4 Send a description of request and/or problem, along with name, work location, and a number where you can be reached to the GroupWise e-mail ID "ush computer." At the To: prompt on your send e-mail screen, type 'ush computer'. These messages will be responded to according to our established service standards (refer to section 3 for service standards and response times).

2.5 Contact the Technology Services Manager at 44227 to request services or to report an unresolved computer related problem.

3. SERVICE AND SUPPORT RESPONSE TIME AND WORKFLOW MANAGEMENT

All requests for service are recorded, if not able to be responded to immediately, and assigned to the appropriate support staff. Requests and/or computer related problems are assigned a priority and responded to as follows:

3.1 High Priority - requests are responded to immediately and in most cases resolved on the same day they are reported. This priority level is dedicated to solving computer-related problems that are impacting a group of users, or user, from being able to access essential information or record/process essential information.

3.2 Medium Priority - requests are responded to within 5 business days and are assigned to computer related problems that are not urgent, as described above, but are impacting a user(s) productivity or ability to communicate. This priority is also assigned when equipment and/or service need to be re-located.

3.3 Low Priority - requests for additional or enhanced service, installation of new hardware and software, or the development on new application programs, that are not currently available to network user(s). The completion date is negotiated with the customer requesting the service.

3.4 Technology Services personnel can be accessed after hours in the event of an emergency or to address an urgent computer related problem. Staff can contact the switchboard, SSRN, or simply call the E-chart Help Desk at USH extension 44676 or dial direct at 801-376-9272. The Network Service Manager may also be reached after hours by paging 801-342-0163.

4. APPROVING NEW AND/OR ENHANCED TECHNOLOGY

Requests for additional and/or enhanced technology are to be directed to the Technology Services Manager, or through other Technology Services personnel as applicable. All technology related assets must be reviewed and approved by the IT manager.

4.1 Requests are submitted by the directors of units, disciplines, or offices.

4.2 Requests are sent to the Technology Services Manager, in writing, and preferably via GroupWise.

4.3 The IT Manager evaluates requests, and if consistent with the technology direction and initiatives sponsored by the Hospitals Executive Staff, or that of the Department of Human Services, the request is prioritized based on 1) it's over priority within the scope of the established IT Strategic Plan, 2) degree of necessity and overall benefit to the Hospital, 3) budget availability, and 4) on a first come first serve basis.

4.4 The work is assigned and an estimated date for work completion will be given. If progress is delayed, the customer is contacted and kept up to date, by the Technology Services personnel assigned.

4.5 If for any reason a request can not be accommodated, or a similar solution provided, an explanation is provided to the requestor.

5. INFORMATION SECURITY AND ACCESS CONTROL

Access to the USH networks, and information technology resources of the Hospital, is managed by Technology Services. Each employee or individual needing access must complete and sign the USH LAN Logon Form, indicating that they have read the DHS Acceptable Use Policy, understand it's contents, and agree to comply. Each employee is given a full copy of the DHS Acceptable Use Policy and the Patient Confidentiality Electronic Signature Agreement, for review, before signing the USH LAN Logon Form. The USH LAN Logon Form must also be reviewed and signed by the employee's Unit Director, Nursing Director, Office Director, or applicable Discipline Director (management level personnel only).

If staff are required to record or review information in patient charts they must also apply obtain a PIN (personal Identification Number) from Medical Records. This is necessary to ensure transaction level security and to provide for additional user authentication. When information is recorded or changed in a patient's chart, the user must supply their PIN number. This PIN is verified with the user ID and password. This provides a second level of authentication that the person using the login ID and password, is in fact the owner of the ID.

The employee can change e-chart passwords and PIN numbers. If users feel that these security codes have been compromised, they should select File, and Change Password PIN. This option is accessed from the E-chart main menu. Users can also contact the E-chart Help Desk at 44676 for assistance.

5.1 A USH LAN Login Form is requested from the Technology Services Office located in the Heninger Building.

5.2 All applicable information must be completed with appropriate Administrator Signature (Unit Administrative Director, Office Director, Discipline Director, or Unit Nursing Director). The employee must read the DHS Acceptable Use Policy, read and sign the USH Patient Confidentiality Electronic Signature Policy, and sign the USH LAN Login Form, indicating that they have read these policies, understand the contents, and agree to comply. The completed LAN Login Form is returned to the Technology Services Office, located in the Henniger Building. A copy of this form is given to HR and placed in the employee's personnel file. A USH LAN Login Form is required for any type of access, i.e., employee, contractor, surveyor, alienist, court reviewer, MHC contact, etc.

5.3 The following information is required in order to obtain access: Full Name (middle initial if available, Job Title, Work Location, Discipline or Office, Supervisor

or on -Supervisor, Clinical or Intern, Required Applications, Employee Signature, and Administrative Signature (management level only).

5.4 If Required Applications are not indicated on the form, then the user will be given access to department standard software only i.e., Windows, Word, USHOPP Manuals, GroupWise, E-staff (employee only), and Netscape. If specific applications and/or access is needed such as: F:\users\all, MedEdge, LEMUR, Microsoft Access, Excel, PowerPoint, or E-chart, they must be listed on the 'Required Applications' section of the form, and approved as listed above.

5.5 Changes to current access privileges must be submitted by the supervisor in writing or sent via E-mail to Technology Services 'ush computer' account. These are filed with the original LAN Logon Form when completed.

5.6 Access to E-staff is given based on Supervisor or Non-supervisor positions. Additional access to the SMT group is limited to AD, UND, and MD's only. Other security groups are granted based on the discipline or office the employee works for and the Access Level provided. The E-staff Executive work group is given to Executive level staff only. Access to the E-staff Administrator group is given with IT Manager or Executive Staff approval only.

5.7 Access to E-chart is granted based on an employee's job title, access level (clinical or intern), and discipline or office. Work groups are assigned to an ID and determine what update, browse, or approval capability a job description clinical scope is authorized for.

5.8 The generic work group is granted, as approved, for read only access to charts when the job title is listed as surveyor, alienist, court reviewer or DLC, mental health center representative, division personnel, or security staff. The generic work group is restricted from printing capability and access to labs.

5.9 Multiple work groups can be granted to a user account, if the work groups are consistent with the clinical scope of the position. This may be required to provide a combination of update, or approval capability, needed for a given function within the hospital. If additional work groups are requested, other than the group that matches their job description, the request is to be forwarded to the IT Manager or Medical Records Director for approval.

5.10 Each job description that requires clinical involvement with patients, has a corresponding e-Chart security work group i.e., e-Chart Psychiatrist, Medical, Medical MD, RN, LPN, etc. These work groups grant browse access to all charts, and allow specific update capability based on the scope of their job class (or clinical position). Additionally, actions are also secured from browse or run capability. Actions (or note types) can only be entered (run) by a user who is in that work group. However, they can be viewed by other work groups as granted.

5.11 Multiple actions can be granted to a work group, given that they are consistent with the clinical scope of the position. This may be required to provide a combination of update or approval capability required for given job classification.

5.12 Medical Records and the IT Information Analyst conducts regular audits of work group access to patient charts to ensure accuracy and appropriateness, and may make changes to work groups as applicable. All access (to include read only) to patient charts is recorded and audited on a monthly basis by Medical Records.

This is done to determine the appropriateness of staff's access, and to reinforce the patient confidentiality policy signed by each employee. If users of E-chart are found to be out of compliance with the confidentiality policy, their E-chart logon privileges may be suspended, removed, or disciplinary action, to include termination, may be taken.

5.13 Reports on work groups and individual access levels are available in e-Chart. These reports will list the specific capabilities granted to work groups and/or employees.

5.14 PIN numbers are required for the recording of information into patient charts to be activated. PIN numbers are assigned to an individual user id and password, and can only be used in conjunction with the assigned user ID. PIN number access is required at the time information is being recorded or approved in the chart. If a valid PIN number does not exist or match, actions or transactions can not be completed. This is to protect the patient and the employee.

5.15 Work groups are established at the direction of the IT Manager, Medical Records Director, Information Management Committee, or Executive Staff only.

5.16 Disputes or questions regarding Information Security are resolved by the IT Manager, Medical Records Director, HR Director, Information Management Committee, or Executive Staff.

5.17 User Accounts for terminated employee's are suspended upon notification and removed from the network after 30 days. Access accounts are to be removed from NetWare, GroupWise, DBArtisan, and e-Security by the assigned Technology Services staff.

5.18 Authorizing Signatures, or Signors (management level signatures approving the establishment of user id/account), are responsible to notify Technology Services, by phone or e-mail, if a user account has terminated, transferred to another position, or needs security work group access adjusted, terminated, or suspended. Technology Services staff are also notified, via email and e-staff, when employees have changed job and/or unit, or who have been terminated, and may take appropriate action without notification from the supervisor/signor.

5.19 In the case of planned personnel actions that might put information and confidentiality at risk, Administrative Signors are required to give notice to Technology Services Staff immediately to suspend access accounts. This should be done prior to, or immediately following, any such action.

5.20 When using E-chart or E-staff, an automatic screen saver, security feature is activated after 10 minutes of inactivity. This clears the window and prompts you for your password to continue charting. When the password is re-entered the user is returned to their active windows. The screen saver can be activated by the user at anytime by pressing the Ctrl key and the L key on their keyboard. Staff is instructed to use Ctrl L to activate the screen saver when they are not directly charting. This is to protect the confidentiality of patient and the logon privileges of the user.

5.21 The Utah State Hospital's computer systems are part of the protected and private Utah State Wide Area Network (WAN). All USH resources connected to the WAN, are behind the ITS Firewall, and as such are protected from unauthorized access. Only authorized IP addresses are allowed access through

the firewall. USH participates in the private network, by not allowing any unauthorized remote connections to USH servers or workstations. Only approved PC Anywhere connections are allowed. These connections are protected with encrypted sessions, and require NDS user id authentication.

5.22 Our Sybase database is also protected from unauthorized access via Windows 2000, Sybase Security (DBArtisan), and Sybase database encryption. No remote NT connections are setup on USH Sybase servers.

6. TECHNOLOGY SERVICES HARDWARE AND SOFTWARE INVENTORY AND LICENSING COMPLIANCE

6.1 Hardware is tracked when issued or moved by serial number, model number, base configuration, employee, and physical location.

6.2 Every workstation must be electrically plugged into a power strip for protection from fluctuations in power. It is the responsibility of every user to insure that the equipment in their possession is protected by a power strip, and properly cleaned. Contact the Network Support line at 44270 for proper cleaning instructions.

6.3 Software distributed by Technology Services is licensed based on our hardware device counts, OEM software products purchased with every new PC, via state purchase contracts, or controlled and purchased according to membership in a related NAL or NetWare access control group. The Technology Services supervisor maintains software licenses. Software licensing compliance, for software residing on USH networks, and distributed to client PC's via NAL, Ghost Images, or installed by Technology Services Staff, is the responsibility of the Technology Services Network Supervisor.

6.4 Software installed on the hard drives of individual PC Desktops is the responsibility of that user. Any such software must support a job-related function and be approved by the discipline and/or office director. The software must be in compliance with all licensing and copyright laws, and the employee who installs such software is responsible to retain the license. Software installation on the hard drives of Nursing or Psych Tech PC's is not permitted, unless approved by the IT Manager.

6.5 Software installed to USH networks must have IT Manager approval, be legally licensed, and used only in accordance with that license. Only legal copies of software are installed. Software compliance audits are run upon request. Any illegal copies of software are to be deleted upon detection.

6.6 Web shots or special screen saver backgrounds are not permitted on Nursing or Psych Tech PC's. Additionally changing PC system configurations, Windows OS profiles, or control panel settings on these PC's is not permitted.

6.7 Technology Services complies with all Department of Human Services Office of Technology, Division of Information Technology Services, and State of Utah Chief Information Officer's policies and procedures.

7. DATA INTEGRITY AND RETENTION

7.1 Backup is performed daily on all data residing on USH production file servers. Backup tapes are moved off-site on a weekly basis to the MS Building,

and off site on a bi-weekly basis to the Utah State Developmental Center. Refer to the Technology Services Network Supervisor's Performance Management Plan, and the USHUSDC Off-Site Data Backup Storage Agreement, for more detail on data backup and verification, restore, and off-site storage procedures. All data backup tapes are properly labeled and expired after two years.

7.2 In the event that system or application software is upgraded or replaced, all information residing on any non-expired data backup tapes or other related media (such as disk or CD-ROM) must be transferred to another accessible media for retention and to maintain accessibility to the data. The Executive Leadership Team must approve this action, and a data migration plan submitted, reviewed, and approved.

7.3 Data that resides on individual Desktop PC hard drives is not backed up by Technology Services. Employee's who maintain information on individual PC hard drives have the responsibility to perform their own data backups as applicable. It is against policy to store or save official USH, or any patient related information on individual PC hard drives.

7.4 To request a restore of lost or damaged information, contact the Network Support Line at 44270 or send an e-mail request to the 'ush computer' e-mail account.

8. SYSTEM AVAILABILITY AND DISASTER RECOVERY PROCEDURES

To ensure continued operation of all production system servers at USH, redundancy measures have been taken to minimize any unscheduled downtime or disruption in service. For additional information related to system maintenance and support procedures, refer to the Technology Services Network Supervisor's Performance Management Plan.

8.1 The E-chart production system and related components have redundancies available in the event of primary system failure. Spare parts or alternative hardware is available as follows: primary disk array and one spare drive, multiple CPU's, spare communication controllers, Ethernet switches, fiber connectors, and related cables are available to re-replace or re-route traffic, and repair hardware failure. In the event that the E-chart primary production system is expected to be out of service for more than one hour, the E-chart 'warm standby' system will be activated. The E-chart warm standby system is a redundant version of E-chart, both hardware and software, that is current within two hours of the primary production system. The 'Warm Standby' system can be operational within three hours. This redundant system allows us to maintain read only access to patient charts and to print critical hard copy information from charts, in the event of prolonged system failure.

8.2 The operational procedures are as follows: 1) E-chart production is restored to the e-Chart staging server, from the most recent backup (backup is done nightly at 1:00 A.M.). 2) E-chart production transaction logs, which are copied to the ush_staging server every two hours, are applied to the restored e-Chart production database on ush_staging. 3) The e-Chart production ini file is changed to point the login window to the ush_staging server. 4) A generic (read only) login ID is created and distributed to essential clinical staff, along with instructions to begin using the ID for read only access to patient charts. 5) Staff are also instructed to use the USH form #USH-201-0801, Electronic System Failure

Backup Note, located on the units, to record essential information, until E-chart production is restored. Once production is restored, all notes, vital signs, or blood sugars, (essential information only recorded on these forms) are to be re-entered into E-chart production. The information should be re-entered into e-Chart by the staff who recorded it on form ush-201-0801, or by a supervisor for that discipline, with reference to who it was recorded by. All ush-201-0801 forms are to be retained in the hard copy chart according to current retention requirements. 6) Staff are instructed to re-schedule non-essential functions such as recording Assessments, Treatment Assessment Notes, Group Notes, etc., until e-Chart production is restored.

8.3 During an emergency, computer operations are maintained, unless otherwise directed by the command center. All USH buildings, with the exception of the Youth and Rampton buildings, are supported with generator power during primary power failures. Computer access is continues during primary power failure.

8.4 In the event of prolonged disaster, which renders distribution of E-chart to unit buildings and workstations, unavailable, access to E-chart can be maintained in the Administration Building's command center. Critical information can then be printed and distributed as applicable. The Administration Building, and all essential system components necessary to operate E-chart, is operational of the backup power generator in that building.

8.5 The command center will give specific instruction to the network supervisor, as to how many PC's and printers need to be installed and connected in the command center, to the USH production servers (to include e-Chart).

Implemented: 3-22-89

Reviewed: 12-90

Revised: 5-92

Revised: 3-93

Revised: 9-95

Revised: 11-98

Revised: 3-02

Revised: 9-03

Chapter: ^{xciii}Therapeutic Environment (TH)

Section 1: Swimming Pool, Gym, and Weight Room

Policy

Utah State Hospital provides exercise facilities (swimming pool, gymnasium, and weight room) for use by patients and employees.

Procedure

1. Exercise facilities are available for employee use Monday through Sunday at the following times:

0500 to 0800

1100 to 1300

1630 to 1800

2130 to 0100

- 1.1 All other times are designated for patient use.
2. Employees obtain a key to the exercise facilities from the Switchboard.
3. Individuals using the swimming pool are required to observe the following rules and guidelines:
 - 3.1 Swim wear is required.
 - 3.2 No cut-offs or other clothing which may shed material is worn in the pool.
 - 3.3 No shoes, food, or drink allowed on pool deck.
4. A certified lifeguard is on duty during use of the swimming pool by patients.
5. Individuals using the weight room are required to wear gym clothing or sweat suits.
 - 5.1 Street shoes are not allowed in the weight room.
6. Patients use the weight room per their ICTP.

6.1 A physical assessment and specified exercise program are included in the ICTP.

7. Patients using the weight room are supervised by a recreational therapist or weight room trained employee.

8. Individuals using the gymnasium are required to wear appropriate gym clothing which includes gym shoes.

8.1 Street clothes during an activity are not allowed.

8.2 Gym shoes have non-marking soles.

9. Patients using the gymnasium are under the supervision of a recreational therapist or approved employee at all times.

Implemented: 5-6-82

Revised: 3-17-86

Revised: 8-17-88

Reviewed: 12-90

Revised: 4-92

Revised: 3-93

Reviewed: 9-95

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Reviewed: 12-00

Chapter: ^{xciv} Therapeutic Environment (TH)

Section 2: Therapeutic Environment

Policy

Each hospital unit establishes environments that are designed to enhance the positive self-image of the patients, and preserve their human dignity.

Procedure

1. The grounds on which the Utah State Hospital is located provide adequate space for several programs to carry out stated goals. When the patients' needs or the programs' goals include the need for outdoor activity, areas and facilities appropriate to the ages and clinical needs of the patients are provided. Many of these activities take place within the community setting, in such buildings as churches and school facilities. Sports such as softball, tennis and basketball are a part of the program on the hospital grounds. The natural terrain of the area provides for outdoor activities which include hiking, fishing, sleigh-riding, team competition, etc. A multiple purpose facility, enhances patient activities by providing stage, auditorium, pool, patient canteen, and other areas appropriate to patient activities.
2. The various hospital units are accessible to handicapped individuals or have as an alternative, a written plan that describes how the handicapped individual gains access for necessary services.
3. Waiting or reception areas are comfortable; and their design, location, and furnishings accommodate the characteristics of patients and visitors, the anticipated waiting time, the need for privacy and/or support from staff, and the goals of the facility.
 - 3.1 Appropriate staff are available in waiting or reception areas to address the needs of patients and visitors.
 - 3.2 Restrooms are available for patients and visitors.
 - 3.3 A telephone is available for private conversations.
 - 3.4 An adequate number of drinking units are accessible at appropriate heights.
 - 3.4.1 If drinking units employ cups, only single-use, disposable cups are used.

4. The Utah State Hospital emergency medical-care resources include the medical director of each unit, nursing staff, and other supervisory staff familiar with the location, contents and use of first-aid supply kits.
 - 4.1 First-aid supplies are kept in appropriate places on each unit.
5. Utah State Hospital programs provide 24-hour care services, and shall consistently emphasize the provision of environments that are responsive to the needs of their unique patient population.
 - 5.1 Each treatment unit strives to provide an environment that reflects a design, structure, furnishings and lighting to promote clear perceptions of peoples and functions.
 - 5.2 Lighting is under the control of the occupants of the lighted area.
 - 5.2.1 Therapeutic exceptions to this general rule are identified and written up in the individual comprehensive treatment plan.
 - 5.3 The hospital has eye-level draped windows in all living areas giving a view of the outdoors.
 - 5.3.1 Wherever possible, beds and other furniture are placed to enhance access to viewing the outdoors.
 - 5.4 On each treatment unit appropriate types of mirrors, which distort as little as possible, are placed in sleeping, bathing, and dressing areas, as well as in the hallways.
 - 5.5 Clocks and calendars are provided to promote awareness of time and season.
6. Ventilation is recognized as contributing to the habitability of the environment, and outside air ventilation is provided to each habitable room by an air-conditioning system and/or by operable windows.
 - 6.1 The ventilation is such as to remove undesirable odors.
 - 6.2 All areas and surfaces are kept free of undesirable odors by daily cleaning with appropriate chemicals to maintain a pleasant atmosphere.
 - 6.2.1 Attending staff and patients are co-responsible for the upkeep of their own living quarters, bed, dresser, and immediate area, with the more technical cleaning administered by the Housekeeping Department.
7. Door locks and other structural restraints are used minimally, and the use of door locks or closed sections is approved and reviewed by the clinical staff, the Administrative Staff, and the Governing Body.
 - 7.1 Patients are encouraged through the responsibilities outlined in their unit programs and their patient self-government processes, to assume responsibility for each other's security by monitoring the doors so an open-door policy may be in effect.
8. The facility has written policies and procedures to facilitate staff-patient interaction, particularly when structural barriers in the therapeutic environment separate staff from patients.

8.1 Utah State Hospital personnel respect the patients' right to privacy by knocking on the door of a patient's room, bathroom, and showers prior to entering.

8.1.1 This is not adhered to during sleeping hours or when personnel enter a room during an emergency.

9. Areas with the following characteristics are available to meet the needs of patients:

9.1 Each hospital treatment unit has areas which are available for a full range of social activities for all patients from two-person conversations to group activities; has attractively furnished areas available where a patient can be alone, when this is not in conflict with the therapeutic prescription for group activities; and has attractively furnished areas to ensure privacy for conversations with other occupants, family, or friends.

10. Hospital treatment units' furnishings and equipment are available to accommodate all occupants, and such furnishings are clean, in good repair, and appropriate for the ages and physical conditions of the patients.

10.1 Repairs to broken items are carried out promptly, and all equipment and appliances are maintained in good operating order.

11. Dining areas are comfortable, and consistent attention is directed at making dining areas attractive and conducive to pleasant living.

11.1 Dining arrangements are based on a logical plan that meets the needs of the patients and the requirements of the program.

11.2 Dining tables seat small groups of patients. Other arrangements may be justified on the basis of the patients' needs, however that justification must be in writing and is found in the unit's written guidelines.

11.3 Staff members may choose to eat with the patients. However, the dining rooms are adequately supervised and staffed by assigned personnel, who provide assistance to patients when needed, and ensure that each patient receives an adequate amount and variety of food.

12. Sleeping areas have doors for privacy.

12.1 In rooms containing more than four patients, privacy is provided by partitioning or placement of furniture.

12.2 The number of patients in a room is appropriate to the ages, developmental levels, and clinical needs of the patients and to the goals of the facility.

12.3 Except when clinically justified in writing on the basis of program requirements, no more than eight patients sleep in a room.

12.4 Sleeping areas are assigned on the basis of the patient's need for group support, privacy, or independence.

12.5 Patients who need extra sleep, whose sleep is easily disturbed, or who need greater privacy because of their age, emotional disturbance, or adjustment problems have single or double bedrooms.

13. Areas are provided for personal hygiene.

13.1 The areas for personal hygiene provide privacy.

13.2 Bathrooms and toilets have partitions and doors.

13.3 Toilets have seats.

14. Good standards of personal hygiene and grooming regarding bathing, brushing teeth, care of hair and nails, and toilet habits are taught and maintained.

14.1 Patients have the personal help needed to perform these activities and are helped both by peer and aide assignments to assume responsibility for self-care as they are able.

14.2 Incontinent patients are cleaned and/or bathed immediately upon voiding or soiling, with due regard to appropriate privacy.

15. Articles for grooming and personal hygiene are available, in a space reserved near the patient's sleeping area and appropriate to the patient's age, developmental level, and clinical status.

15.1 When clinically indicated and with appropriate documentation, a patient's personal articles may be kept under lock and key by the staff.

16. Ample closet and drawer space is provided for the storage of personal property and property provided for the patient's use.

16.1 Lockable storage space is provided.

17. Patients are allowed to keep and display personal belongings and to add personal touches to the decoration of their rooms.

17.1 The treatment units have written rules to govern the appropriateness of such decorative display.

17.2 If access to potentially dangerous grooming aids or other personal articles is contra-indicated for clinical reasons, the professional staff explains to the patient the conditions under which the articles may be used and documents the clinical rationale for these conditions in the patient record.

17.3 If the hanging of pictures on walls and similar activities are privileges to be earned for treatment purposes, the professional staff explains to the patient the conditions under which the privileges may be granted and documents the treatment and granting of privileges in the patient's record.

18. On-unit industrials are provided to allow patients to assist in maintaining a clean, therapeutic environment.

18.1 Such responsibilities are clearly defined in writing, and staff assistance and equipment are provided as needed.

18.2 Descriptions of such responsibilities are included in the patients' orientation program.

18.3 Documentation is provided that these responsibilities have been incorporated into the patient's treatment plan.

19. Patients are allowed to wear their own clothing.

19.1 If clothing is provided by the program, it is appropriate and is not dehumanizing.

- 19.2 Training and help in the selection and proper care of clothing are to be available as appropriate.
- 19.3 Clothing is suited to the climate.
- 19.4 Clothing is becoming, in good repair, of proper size, and similar to the clothing worn by the patient's peers in the community.
- 19.5 An adequate amount of clothing is available to permit laundering, cleaning, and repair.
20. A laundry room in which a patient may wash clothing is accessible on each of the treatment units.
21. The use and location of noise-producing equipment and appliances, such as televisions, radios, and record players, does not interfere with other activities or the therapeutic program.
22. A place and equipment are provided for table games and individual hobbies.
- 22.1 Toys, equipment, and games are stored on shelves that are accessible to patients as appropriate.
23. Books and magazines are available from the hospital patient library.
- 23.1 Daily newspapers are brought to each unit.
24. Arts and crafts materials are available in accordance with patients' recreational, cultural, and educational backgrounds and needs, through programmed efforts, under the direction of the activity service.
25. Each Utah State Hospital treatment unit formulates its own policy regarding the availability and care of pets and other animals, consistent with the goals of the Utah State Hospital and with the requirements of good health and sanitation.
(See Infection Control (IC), Section 3: Pets)
26. Each treatment unit has facilities available which allow the serving of snacks and appropriation of meals for special occasions and recreational activities such as baking, making popcorn or candy, and so on.
- 26.1 These facilities permit patient participation.
27. Unless contra-indicated for therapeutic reasons, Utah State Hospital treatment units accommodate the patients' need to be outdoors through the use of nearby parks and playgrounds, adjacent countryside, and Hospital grounds.
- 27.1 Recreational facilities and equipment are available and are consistent with the patients' needs and the therapeutic program.
- 27.2 Recreational equipment is maintained in working order.

Implemented: 2-10-82
Revised: 12-18-85
Revised: 7-89
Reviewed: 12-90
Revised: 4-92
Revised: 3-93
Reviewed: 9-95

Revised: 6-98
Reviewed: 2-02

Chapter: ^{xcv}Therapeutic Environment (TH)

Section 3: Secure Units

Policy

Utah State Hospital maintains secure units for the treatment of patients who have been identified as a danger to themselves or others through the judicial system and/or represent a security risk.

Procedure

1. Unit doors are to be locked, unless the program structure allows an exception.
 - 1.1 The Unit Clinical Director, with the approval of the Hospital Clinical Director and Superintendent/CEO, may allow unit doors to the outside to be open under conditions which are specified in writing.
 - 1.2 Inner unit doors may also be locked to improve security as needed.
2. If a sufficient number of patients do not require a secure unit with locked doors, the unit populations may be regrouped through staff determination to allow a less restrictive environment.
3. Patients may receive passes that allow them access to the hospital campus, facilities, and/or community as approved by the Unit Clinical Director.

*Implemented: 7-89
Reviewed: 12-90
Revised: 4-92
Reviewed: 3-93
Reviewed: 9-95
Reviewed: 6-98
Reviewed: 2-02*

Chapter: xcvi Therapeutic Environment (TH)

Section 4: Barber and Beauty Services

Policy

The following procedures direct the use and management of the barber and beauty shop facilities at the Utah State Hospital. Respect and consideration are given to cultural and religious beliefs.

Procedure

1. Two licensed beauticians are employed to provide barberbeauty shop services to patients.
 - 1.1 Barberbeauty shop services include but are not limited to hair cutting and styling and the application of permanent waves.
2. Each unit has a scheduled day and time available for appointments with the barberbeauty shop which is located in the Owen P. Heninger Building.
 - 2.1 The barberbeauty shop schedule is posted on each unit.
 - 2.2 Patients schedule appointments with the barberbeauty shop through unit personnel.
 - 2.3 The unit personnel call weekly to confirm the appointments with the barberbeauty shop manager.
3. Changes by the patient, unit, or manager are made as soon as possible so as to not inconvenience others scheduled to use the shop.
4. The use of private facilities off campus is determined by the patient's activity status and available funds.

Implemented: 7-89
Reviewed: 12-90
Reviewed: 4-92
Reviewed: 3-93
Reviewed: 9-95

Reviewed: 6-98
Reviewed: 12-00

Chapter: xcvii Utilization Review (UR)

Section 1: Utilization Review Standards

Policy

Utah State Hospital provides for and demonstrates appropriate allocation of its resources through an effective utilization review program.

Procedure

1. The utilization review program addresses overutilization, underutilization, and inefficient scheduling of resources.
2. The hospital implements a written plan that describes the utilization review program and governs its operations.

The utilization review plan is approved by the medical staff, administration, and governing body.

3. The utilization review plan includes at least the following:
 - 3.1 A delineation of the responsibilities and authority of those involved in the performance of utilization review activities, including members of the medical staff, any utilization review committee(s), non-physician health-care professionals, administrative personnel, and, when applicable, any qualified outside organization contracting to perform review activities specified in the plan.
 - 3.2 A conflict-of-interest policy applicable to all involved in utilization review activities.
 - 3.3 A confidentiality policy applicable to all utilization review activities, including any findings and recommendations.
 - 3.4 A description of the method(s) for identifying utilization-related problems, including the appropriateness and medical necessity of admissions, continued stays, and supportive services, as well as delays in the provision of supportive services.
 - 3.5 The procedures for conducting concurrent review, including the time period within which the review is to be initiated following admission to be used in assigning continued-stay review dates.
 - 3.6 A mechanism for the provision of discharge planning.
4. Concurrent review focuses on those diagnoses, problems, procedures, and/or

practitioners with identified or suspected utilization-related problems.

Source of payment is not the sole determinant in identifying patients for concurrent review.

5. To facilitate discharge as soon as an inpatient level of care is no longer required, discharge planning is initiated as early as a determination of the need for such activity is made.

6. The hospital's utilization review program, including the written plan and criteria, is reviewed and evaluated at least annually and is revised as appropriate to reflect the findings of the hospital's utilization review activities.

Implemented: 3-92

Revised: 8-95

Revised: 6-98

Revised: 3-02

Chapter: xcviii Utilization Review (UR)

Section 2: Utilization Review Plan

Purpose

The Utah State Hospital Utilization Review Plan (USH-URP) has several purposes:

1. To appraise appropriate and efficient utilization of all services provided by the Utah State Hospital.
2. To assist in the maintenance of high quality care of patients, as state resources allow, in the Utah State Hospital.
3. To make recommendations to appropriate administration and/or clinical personnel to eliminate inefficient or unnecessary utilization of services.

Authority

The development and implementation of the Utilization Review Program has been authorized by the Governing Board and approved by the Medical Staff Bylaws.

Mission

USH programs serve patients who have psychiatric illness and whose adaptive functioning is moderately to severely impaired. These patients require continuous nursing supervision for response to treatment and can be expected to benefit from an active treatment designed to improve their adaptive functioning, to prepare the patient for placement in a less restrictive level of care, and/or to prevent further deterioration.

Scope of Service

The Utilization Review Committee reviews the services to patients furnished by members of the medical staff and the Utah State Hospital professional staff. This includes, but is not limited to the medical necessity of admissions; duration of stay; professional services provided, including medications; discharge planning; and the efficient use of personnel and facilities in order to promote maximum treatment benefit.

Organization

The Utilization Review Committee (URC) is a permanent, standing committee of Utah State Hospital. It maintains effective liaison with the committees of the Medical Staff and is considered part of the Continuous Quality Improvement Program.

Functions of the Utilization Review Committee Include, But Are Not Limited To:

1. Utilization review is carried out for all patients in the hospital regardless of source of payment.
2. Admission, continued-stay, and quality-improvement screens are conducted under the direction of the Utilization Review Committee by the Utilization Review Coordinator and staff.
3. The Utilization Review Committee is responsible for screening patient stays according to USH criteria for admission, continued-stay, and discharge.
4. The Utilization Review Committee is responsible for the on-going evaluation of care.
5. The Utilization Review Committee addresses over-utilization, under-utilization, and inefficient scheduling of resources.

Membership

1. The membership of the Utilization Review Committee (URC) includes two psychiatrists or more, including the Hospital Clinical Director or designee, who are knowledgeable and skilled in the diagnosis and treatment of mental diseases. There is also participation of other professional disciplines and services and professional staff from the Medical Records Department. The chairperson is a physician appointed by the Hospital Clinical Director with the approval of the hospital administration. The Committee Manager is the Utilization Review Coordinator.

2. Members of URC include:

Chairperson (MD, DO)

Committee Manager (Utilization Review Coordinator is the UR Committee Manager)

Hospital Clinical Director or designee (MD DO)

Program Administrator

Assistant Superintendent

Director of Nursing Services or representative

Medical Records Manager

Representatives of treatment units professional disciplines may attend meetings

3. A secretary provides clerical services for reports.

4. Non-physician members of URC, after being recommended by their disciplines, are appointed to serve one-year terms, renewable annually in July, with the concurrence of the Hospital Administration Staff.

Conflict of Interest

1. No member of the Committee participates in the review of a case in which heshe has been directly responsible for care of the patient.
2. Members of the URC are approved by the SuperintendentHospital Clinical Director.

Frequency of Meetings

URC meetings are held quarterly with the datetime determined by the Chairperson and Manager. Additional meetings may be called at the discretion of the Chairperson.

Records and Reports

The following reports are kept:

1. Minutes of each meeting are prepared after each meeting and are distributed by the URC secretary to:
 - Superintendent
 - Hospital Clinical Director
 - Director of Quality Improvement
 - URC members
 - Other staff as deemed necessaryMinutes comply with the USH committee minutes format.
2. All Utilization Review records and reports are maintained by the Utilization Review Committee Manager. The UR records include the UR Admission Review, Second Step Admission Review, Continued Stay Review, Second Step Continued Stay Review, and Utilization Review Documentation USH-29-0596.
 - 2.1 A record of Utilization Reviews (Utilization Review Documentation USH-29-0596) will be kept in the patient's chart and will be a permanent part of the patient record.
 - 2.2 The Utilization Review Admission Review and the Utilization Review Continued Stay Review form will be maintained in the UR Office for six months and then be destroyed.
 - 2.3 Forms documenting Second Step Reviews will be maintained in the UR Office for five years and then be destroyed.
3. The names of individual patients in all summary utilization review reports are kept confidential. Patients are identified by hospital number andor first name and last initial.

Chairperson

The Chairperson of the Utilization Review Committee:

1. Is a member of the Medical Staff.
2. Reports utilization review activities to the Medical Staff and other designated individuals or groups.
3. Chairs the meetings of the Utilization Review Committee.

4. Ascertains if conflicts of interest are present and assigns alternate committee members to complete the work.
5. Signs the minutes of the Utilization Review Committee.

Committee Manager

The Utilization Review Committee Manager is responsible for supervising screening activities. The Utilization Review Committee Manager is also the Utilization Review Coordinator.

The Committee Manager:

1. Coordinates the screening of all admissions to Utah State Hospital to determine if the admissions meet the hospital admission criteria.
2. Coordinates the screening of all continued stays at Utah State Hospital to determine if the stay meets the hospital continued stay criteria.
3. Directs the screening functions performed by Utilization Review staff.

Method of Review and Use of Criteria

1. A physician must certify for voluntary and civil commitment patients that inpatient services at Utah State Hospital are needed at admission, by the 14th day (ICTP Staffing), and recertify at least every 30 days thereafter in order to meet Federal recertification requirements.
2. The admission and continued stays of all patients are screened according to approved criteria.
3. Criteria used by URC to determine the necessity for admission and continued stay have been approved by the Utah State Hospital Utilization Review Committee in concurrence with the State Mental Health Laws (Utah Code Annotated 1953, as amended 1981).
4. All voluntary and civil commitment patients must meet the criteria of Policy 12 to be admitted (USHOPP, Chapter: Admission).
5. Within 24 hours of admission, a psychiatrist and a medical practitioner must make an assessment of each patient's need for care in the hospital. These assessments meet Federal, State, and USH requirements. The medicalpsychiatric assessment must include:
 - a) Medical History
 - b) Record of Mental Status
 - c) Onset of illness and the circumstances leading to admission
 - d) Description of attitudes and behaviors
 - e) Estimated intellectual functioning, memory function, and orientation
 - f) Inventory of the patient's assets in a descriptive, not interpretative fashion
 - g) Diagnosis(es): according to DSM IV and ICD-9 CM

Summary of present medical functioning

Medical history

Mental and physical functioning

AIMS screen

- h) Certification or non-certification by the physician concerning admission to USH
 - i) Initial active treatment plan
6. Closer scrutiny is applied to cases where there are indications of:
- a) Over-utilization
 - b) Under-utilization
 - c) Inefficient scheduling of resources
 - d) Extended length of stay
7. Chart information screened/reviewed includes:
- a) Patient identification (name and social security number)
 - b) Identification of attending physician
 - c) Date of admission
 - d) Diagnosis(es) or problem(s)
 - e) Plan of care
 - f) Clear documentation of justification for admission/continued stay.
 - g) All commitment papers

Admission Review

1. Notification of Admission:
 - 1.1 The Utilization Review Coordinator accesses admission data through the USH computer system.
2. Assignment of an Initial Continued-Stay Review Date
 - 2.1 The Utilization Review Committee Manager schedules the First-Step Screening of the patient within 48 hours of admission during regular working hours.
3. First-Step Screening:
 - 3.1 Within 48 hours of admission during regularly scheduled working hours, a Utilization Review nurse screens the patient record to make an initial determination of whether or not the admission is justified.
 - 3.2 This determination is based upon the documentation available in the medical record. The specific portions of the record being examined during the admission screening are:
 - 3.2.1 The Initial Psychiatric Assessment is completed by a psychiatrist within 24 hours of admission. This assessment includes a summary of mental and physical functional levels, diagnosis, prognosis, and explicit recommendation by the physician with respect to admission. The rationale for ordering medication is also included in the admission progress note.

3.2.2 Physician Orders, as appropriate for medications, treatment, restorative and rehabilitative services, therapies, activities, social services, diet, and special procedures recommended for the health and safety of the patient.

Satisfactory First-Step Screening

1. If documentation supports that admission is justified in accordance with specific criteria, an Initial Continued Review Date is established at that time, which is not to exceed 30 days from the admission review.
2. When the Initial Continued Stay Review has been established, the Utilization Review nurse completes the UR Admission Review form, which is maintained in the Utilization Review Office for six months.
3. The Utilization Review nurse enters the results of the review on the Utilization Review Documentation form in the patient's chart.

Unsatisfactory First-Step Screening

1. If documentation does not justify necessity of admission, the UR Admission Review form is completed, indicating that the first-step screening was unsatisfactory and the reasons. The Utilization Review staff determines a 48-hour rescreening date.
2. The Utilization Review nurse enters the results of the review on the Utilization Review Documentation form in the patient's chart.
3. The mental health center is notified that the admission will be referred for a second-step review and invited to present additional information, if desired, within 24 hours.
4. One copy of the Admission Review is forwarded to the Chairperson of the URC and one copy is sent to the attending physician.

Second-Step Review

1. The second-step physician reviewer is a psychiatrist not responsible for the care of the patient.
2. The Utilization Review nurse supplies the second-step physician with a copy of the completed Admission Review form and a Second-Step Admission Review form for him/her to complete.
3. Any information received from the mental health center is forwarded to the second-step physician reviewer for his/her consideration.

Satisfactory Second-Step Review

1. If the physician reviewer determines that the admission is appropriate, he/she completes and signs the Second-Step Admission Review and returns it to the Utilization Review Coordinator.
2. The Utilization Review Committee Coordinator completes the Utilization Review Documentation form in the medical record. The Utilization Review Office maintains the Admission Review form and the Second-Step Admission Review form on file for five years.

Unsatisfactory Second-Step Review

1. If the physician reviewer has reason to believe that the admission is not justified, he/she confers with the attending physician and affords an opportunity for the attending physician and the clinical team to present their views. If the physician reviewer concurs with the attending physician that admission is justified, and if documentation exists to support this determination, a Continued-Stay Review Date is established.
2. If, after conferring with the attending physician, both the physician reviewer and the attending physician agree that the admission is not justified, arrangements are made for the patient's discharge.
3. If, after conferring with the attending physician, the physician reviewer and the attending physician do not agree, the case is referred to the Hospital Clinical Director for final determination within 48 hours.
4. If the HCD second-step review decision is that criteria for Admissions have not been met, notification of this decision is sent by the URC Chairperson within 24 hours to:
 - a) Hospital Superintendent
 - b) Hospital Clinical Director
 - c) Unit Clinical Director
 - c) Unit Administrative Director
 - e) Director of Quality Resources
 - d) Business Department
 - e) Medicaid agency as appropriate
 - f) Appropriate court through Legal Services Manager
 - g) Treatment Coordinator, to inform patient/family
 - h) Mental Health Center

A copy of the letter notifying the above of the decision is kept on file by the Utilization Review Committee Manager, in the Utilization Review Office.

5. The Utilization Review Committee Coordinator completes the Utilization Review Documentation form in the medical record. The Utilization Review Office maintains the Admission Review form and the Second-Step Admission Review form on file for five years.

Justification after Second-Step Review

1. If the third physician (HCD) agrees with the attending physician that the admission is justified, a Continued Stay Review Date is established.
2. The Utilization Review Coordinator completes the Utilization Review Documentation form in the patient's record and maintains the Admission Review form and the Second-Step Admission Review form on file in the Utilization Review Office for five years.
3. Notification of the decision is sent to:
 - a) Hospital Superintendent
 - b) Hospital Clinical Director

- c) Unit Clinical Director
- d) Unit Administrative Director
- e) Director of Quality Resources
- f) Mental Health Center

Continued Stay Reviews

When the Continued Stay Review date is assigned, it is documented on the Utilization Review Documentation form.

First-Step Screening Criteria:

1. On or before the Continued Stay Review Date, the Utilization Review Coordinator screens the patient medical record to make an initial determination of whether or not Continued Stay is justified. This determination is made by reviewing documentation in the medical record, which clearly indicates compliance with criteria for extending the initial length of stay. These include:

- 1.1 Treatment Plan review notes at least every 30 days.
- 1.2 Individual Comprehensive Treatment Plan (ICTP), which is updated at least every 90 days.
- 1.3 Progress notes, which document implementation of the ICTP.
- 1.4 Physician's Orders as appropriate for medications, treatment, restorative and rehabilitative services, therapies, activities, social services, diet, and special procedures recommended for the health and safety of the patient.
- 1.5 Any other pertinent areas indicated by the ICTP, such as tests and procedures, *i.e.*, EEG.

Satisfactory First-Step Screening:

- 1. The process for Initial Continuous Stay and subsequent Continued Stay remains the same as stated for the Admission Review.

Unsatisfactory First-Step Screening:

- 1. If documentation cannot justify Continued Stay, the Continued Stay Review form is completed, indicating that the first-step screening was unsatisfactory and the reasons. A copy of the form is forwarded to the Chairperson of URC, and one is given to the attending physician. The Utilization Review Coordinator enters the results of the review and a 48 hour rescreening date on the Utilization Review Documentation form in the patient's chart.
- 2. The mental health center is notified that the patient has been referred for a second-step review for continued stay, and invited to submit any comments input within 24 hours.
- 3. The attending physician responds within 48 hours, indicating that appropriate documentation has been entered in the medical record, which is then re-examined.
- 4. If the attending physician fails to respond within 48 hours, or if the documentation has not been entered in the medical record, it is then re-examined.

Satisfactory Second-Step Review:

1. If the physician reviewer has reason to believe the Continued Stay is not justified, heshe confers with the attending physician and affords himher and the clinical team an opportunity to present their views. If the physician reviewer concurs with the attending physician that continued stay is justified, and if documentation exists to support this determination, a subsequent continued stay review date is established
2. The physician reviewer completes the Second-Step Continued Stay Review form and returns it to the Utilization Review Coordinator.
3. The Utilization Review Coordinator enters the results of the Second-Step Review on the Utilization Review Documentation form in the patient's medical record. The Utilization Review Office maintains the Continued Stay Review form and the Second-Step Continued Stay Review form on file for five years.
4. Notification of the decision is sent to:
 - a) Hospital Superintendent
 - b) Hospital Clinical Director
 - c) Unit Clinical Director
 - d) Unit Administrative Director
 - e) Director of Quality Resources
 - f) Mental Health Center

Adverse Determinations

1. If, after conferring with the attending physician, both the physician reviewer and the attending physician agree that Continued Stay is not justified, arrangements are made for the patient's discharge.
2. If, after conferring with the attending physician, the physician reviewer and the attending physician do not agree, the case is referred to the Hospital Clinical Director..
3. If the Hospital Clinical Director agrees with the physician reviewer that continued stay is not justified, heshe signs the UR form, and arrangements are made to discharge the patient. The attending physician and the clinical team have the right to appeal to the full Utilization Review Committee
4. If the final second-step review decision is that criteria for Continued Stay have not been met, notification of this decision is sent by the Chairperson of URC within two working days to:
 - a) Superintendent
 - b) Hospital Clinical Director
 - c) Unit Clinical Director
 - d) Unit Administrative Director
 - e) Business Office
 - f) Director of Quality Resources

- g) Medicaid agency as appropriate
- h) Appropriate court through the Legal Services Manager
- i) Treatment Coordinator, to inform patient/family

A copy is maintained by the Utilization Review Office.

5. The Utilization Review Committee Coordinator completes the Utilization Review Documentation form in the medical record. The Utilization Review Office maintains the Continued Stay Review form and the Second-Step Continued Stay Review form for five years.

Justification after Second-Step Review:

1. If the Hospital Clinical Director agrees with the attending physician that the continued stay is justified, a subsequent Continued Stay Review Date is established.
2. The Utilization Review Coordinator makes the appropriate entries on the UR Documentation form in the patient's chart.
3. Notification of the decision is sent to:
 - a) Hospital Superintendent
 - b) Hospital Clinical Director
 - c) Unit Clinical Director
 - d) Unit Administrative Director
 - e) Director of Quality Resources
 - f) Mental Health Center
4. The Utilization Review Coordinator maintains the Continued Stay Reviews form and the Second-Step Continued Stay Review form on file for five years.

Subsequent Continued Stay Review

The Subsequent Continued Stay Review is completed according to accepted criteria on length of stay. At the expiration of such further stay, the case is reviewed in like manner with such review being repeated according to accepted criteria, so long as medical-psychiatric necessity for the stay exists.

Discharge Review Mechanism

1. Discharge planning begins at admission with the Initial Psychiatric Assessment by the admitting psychiatrist.
2. Within the first week of admission, a social worker is assigned to assist with discharge planning in compliance with Policy 12 of the Division of Substance Abuse and Mental Health.
3. Discharge planning is reviewed at least every 30 days by the assigned social worker and at least every 90 days by the treatment team.
4. Discharge planning updates are documented in the progress notes and the ICTP. These are reviewed by the UR Coordinator on a regularly scheduled basis.
5. Discharge planning problems encountered by the assigned social worker are

referred to the unit clinicaladministrative director, director of the discipline, and the URC.

6. Rapid readmissions (patients readmitted within 30 days of discharge) and Medical Separations are reviewed by the UR Committee.

Resource Utilization Review

On a scheduled basis, the Utilization Review Committee examines how staff and space are utilized. The review detects trends in over- or under-utilization of space and resources. The Utilization Review Committee reviews the annual reports of the Director of Disciplines, Services, Units, and Departments. The Assistant Superintendent is a member of the URC and reports annually about the budget in relation to personnel, services, and facilities.

The findings, conclusions and recommendations of these reviews are submitted to the appropriate persons.

Annual Review

Annual reviews of the Utilization Review program are made by the Utilization Review Committee. Updated length of stay statistics are completed as part of the review. All major aspects of the Utilization Review Program examined include the goals and objectives and organization responsibilities of members; criteria for admission, continued stay, and discharge; and resource utilization. A report of this review is submitted to the Hospital Clinical Director and the Superintendent. Appropriate changes in organization, areas of responsibility, criteria, and methodology take place as soon as approved.

Revised: 7-83

Revised: 6-85

Revised: 7-87

Revised: 10-88

Revised: 12-90

Revised: 3-92

Revised: 6-92

Revised: 8-95

Revised: 6-96

Revised: 3-98

Chapter: ^{xcix} Volunteer Services (VS)

Section 1: Volunteer Services

Mission Vision

It is the hospital's goal to involve volunteers in a variety of experiences which will utilize the volunteer's skill and interest and at the same time enrich patient's lives and encourage them to enjoy new experiences and establish personal relationships with others. It is Utah State Hospital's desire to have a positive impact on the community's image of mental illness and the treatment of the mentally ill and to educate the community and encourage community awareness and support.

Definition of Volunteer Services

"Volunteer Service" is any service performed on a a voluntary basis, without compensation, under the general supervision of, and on behalf of the Utah State Hospital. Volunteers complement but never replace the paid hospital personnel, they should decline nursing, housekeeping and other duties performed by paid staff. Volunteers should never accept a duty for which they are untrained or feel uncomfortable performing. Volunteers consist of groups or individuals donating their time, energy, and expertise to the Utah State Hospital through a variety of programs and activities, and working through various service areas and departments at the Hospital.

Recruitment

Recruitment of Volunteers is accomplished on an on-going basis through a combination of channels which assist in helping the public to be aware and interested in the treatment programs and needs of the Utah State Hospital. These channels include:

1. Volunteer recruitment listings which are posted or published in newsletters with United Way, local religious affiliations, private organizations, schools and universities, and on internet.
2. Public relation campaigns initiated by Utah State and those initiated through the Division of Substance Abuse and Mental Health, i.e., Mental Illness Awareness Week, Forgotten Patient Christmas Project, conferences & workshops, sponsored by Utah State Hospital or the Division of Substance Abuse and Mental Health.
3. Volunteer hours required as part of course curriculum through Brigham Young University and Utah Valley State College.

4. Patient panels, hospital employee's participation in public speaking engagements, presentations in conferences and workshops, and employee involvement in community clubs, groups, and religious organizations.
5. Volunteers who have worked with our programs and were impressed enough to recommend volunteering to others.

Policies

All volunteer services must be approved by the Superintendent of the Utah State Hospital. (Attachment 1)

Volunteers are considered a government employee for the purpose of:

- a. receiving workers' compensation medical benefits for injuries and occupational diseases incurred while a volunteer at Utah State Hospital (title 35, Chapter 1 and 2);
- b. liability protection and indemnification normally afforded paid government employees (Volunteer Government Workers Act 67-20-3)
- c. the operation of motor vehicles or equipment if the volunteer is properly licensed, has successfully completed defensive driving course, and is authorized by Utah State Hospital administration (USHOPP, Chapter: Volunteer Services (VS, Section 2)

Volunteer Director

Volunteer Services will be coordinated through the Utah State Hospital Volunteer Director. The Volunteer Director will be responsible to train the Service Area Coordinators concerning rules that govern the activities, functions and duties that the volunteers will be performing.

The Volunteer Director will complete a yearly report of all volunteers, hours of service, and the number of community service groups assisting with volunteer services which will be submitted to the Executive Director of the Department of Human Services.

Service Area Volunteer Coordinators

Each treatment service area and department utilizing volunteers will assign a Service Area Volunteer Coordinator who will work directly with the Volunteer Director to establish needed volunteer programs and improve current programs. The Service Area Volunteer Coordinator will be responsible to see that the volunteers complete their time cards each time they work, and will meet with the volunteers quarterly or at the end of their work assignment at which time an evaluation will be completed.

Initial Interview

Volunteers will have an initial interview with the Volunteer Director at which time an application will be completed. The Volunteer Director will take into consideration the information included on the application and will consider information provided in the personal interview to determine the placement area. The volunteer's skills, interests, past experiences and the volunteer's availability will help to determine the placement area.

Background Checks

Criminal background checks through the National Criminal Identification Center will be initiated on each volunteer that is oriented to the hospital. The volunteer will be required to complete and sign an Informed Consent and Release of Liability form enabling the

hospital to initiate a background check. Background checks are not initiated for one-time only visitors (i.e., church visitors, castle workers, choir groups, etc.).

Hospital Orientation

An orientation to hospital policies and procedures will be conducted at the initial interview with the Volunteer Director. Each volunteer will be advised of confidentiality and patients rights issues. Orientation will also cover the following topics: resources for volunteers, dress standards, infection control, fire drills, violenceescape procedures, escorting of patients, suggestion boxes, ID badges, hospital campus, and parking facilities. Documentation of orientation and notification of hospital policies will be documented in writing and kept on file with the Volunteer Director.

Volunteers who are working at the Hospital in conjunction with religious activities or church sponsored groups will be oriented by the leaders of their particular organizations (LDS, Catholic, Presbyterian etc.). Documentation of orientation must be sent to the Hospital Volunteer Director and must include the names of the volunteers, and date of the orientation, and a list of the topics addressed. Each religious organization will assign a volunteer coordinator to work in conjunction with the Hospital Volunteer Director and will insure that the needed documentation is submitted. The church volunteer coordinator will complete a activity request form and submit it to the Volunteer Director which will include pertinent information about the activity being requested, i.e.. type of activity, date, time, accommodations needed, etc. The volunteer Director will contact the service area volunteer coordinator to make arrangements and then will notify the church volunteer coordinator. The service area volunteer coordinator will complete the Group Activity Participation Roll at the time of the activity which will list all participants.

Service Area Orientation

Service Area Orientation specific to the service areadepartment will be conducted by the Service Area Volunteer Coordinator. Service Area Orientation will be documented in writing and verification will be sent to the Director of Volunteer Services to be kept on file. The volunteer's work schedule will be the responsibility of the Service Area Volunteer Coordinator. Hours will be submitted to the Volunteer Director on a quarterly basis along with the number of volunteers working and an estimated dollar amount for any monies or cash-in-kind donations made directly to the service area.

Volunteer Evaluations

Evaluations will be completed quarterly, or at the completion of the work assignment. The Service Area Volunteer Coordinator will complete the evaluation and meet with the volunteer to review job performance. A copy of the evaluation will be sent to the Volunteer Director to be place in the volunteer's file.

Job Descriptions

Service Area Coordinator's will initiate job descriptions for all volunteer positions. The job description will cover exactly what is expected of the volunteer and will include basics requirements and duties to be performed. Special knowledge or experience, unique skills or abilities necessary to perform the duties will be stated. The Volunteer Director will give each volunteer a copy of the job description for their assigned position at the initial interview.

Volunteer Categories

Volunteers are divided into four separate and distinct categories in order to comply with Utah State Risk Management and State Personnel policies and procedures and to

determine how orientation and placement will be completed.

1. **Religious Activities & Meetings** - includes LDS church meeting and programs (visiting teaching, home teaching), Catholic services, non-denominational services, clergy visits etc. Volunteers in this category are oriented and assigned by the religious organization with which they are affiliated.
2. **Religious Sponsored Activities** - are dependent upon hospital staff participation in order to coordinate the activity, such as softball games, quilting groups, individual activities, etc. Volunteers in this category are oriented and assigned by the religious organization with which they are affiliated. A volunteer coordinator assigned through the specific organization will be assigned and will be responsible for documenting orientation, numbers of volunteers, hours volunteered, schedule of activities. This documentation will be sent to the Hospital Volunteer Director on a monthly basis.
3. **Hospital Activities - Church Participation is Requested** - Forgotten Patient Christmas Project, Clothing Center, escorting assistance, etc. Volunteers in this category are oriented and placed by the Hospital Volunteer Director.
4. **Hospital Sponsored Activities** - volunteers are recruited from the community and through universities and school programs. Volunteers in this category are oriented and placed by the Hospital Volunteer Director.

Programming

Current

Volunteers are utilized in a wide variety of areas throughout the Utah State Hospital. Their skills and expertise are essential to many of the programs and groups held on an on-going basis. The areas which are currently using volunteers are:

1. Recreation Therapy - volunteers are used in recreation activities such as softball, bowling, swimming, etc. Volunteers are also used as one-to-one's for specific patients.
2. Elementary School - volunteers are used as tutors to assist with academic subjects.
3. Excel House - volunteers are utilized in all of the various teams working at Excel House (horticulture team, clerical team, food service team, housekeeping team).
4. Physical Therapy - volunteers are used to assist with various therapy treatments and also as escorts.
5. Library - volunteers are involved in all normal library activities and also in assisting the patients to make book selections and music selections.
6. Swimming Pool, - volunteers assist with aqua-aerobic classes and helping with maintenance of pool equipment as well as recreation equipment.
7. Beauty Shop - volunteers are involved by providing styling of hair, manicures, make-up application, etc.
8. Clothing & Sorting Center - volunteers help to sort used clothing for cleaning or discarding and help display the clothing in the clothing center. Volunteers also assist patients in selecting clothing items.

Future Programming

Many of the hospital's needs for volunteers are now being filled by students from Brigham Young University and Utah Valley State College. These students are required to complete from 26 volunteer hours and most are not interested in volunteering for a longer period of time. The Hospital would like to organize and implement a program which encourages volunteers from the community to become involved in hospital programs and become interested in volunteering on a longer-term basis.

This group of volunteers would establish a base for the formation of an auxiliary organization whose services could provide:

1. **Fund Raising** - support from local businesses, bazaars, craft shows, Haunted Castle, Forgotten Patient Christmas Project, etc.
2. **Special Interest Groups** - would assist with treatment teams in conducting various group settings such as social skills groups, communication groups, hygiene, cooking, arts & crafts, reading, music etc.
3. **Extended Canteen Hours** - supplying needed assistance to open the Canteen on weekends and/or evening hours.
4. **Library Services** - would allow the library to be open on weekends and days that the regular librarian is not at work. Also a book cart program could be initiated to allow patients unable to come to the library to check out books.
5. **Specific Service Area Requests** - volunteers with specific talents could be used on an individualized basis depending on the needs of the various service areas (adult, geriatric, pediatric).
6. **Clothing Center** - extended the hours that the center is open to patients and establish relationships with various businesses in the area for donations of clothing and other items.

Implemented: 7-83

Reviewed: 8-85

Revised: 3-88

Reviewed: 1-91

Revised: 4-92

Implemented: 1-95

Revised: 3-02

Chapter: c Volunteer Services (VS)

Section 2: Volunteers Operating State Vehicles

Policy

Utah State Hospital allows volunteers to operate state vehicles upon production of required documentation, completion of the Utah Defensive Drivers course and approval by the Unit Director and the volunteer's direct supervisor.

Definitions

Volunteer means any person who donates services without pay or other compensation except expenses actually and reasonably incurred as approved by the supervising agency and is designated, oriented and approved by the Hospital Volunteer Coordinator.

Supervising Agency means the Utah State Hospital.

Procedure

1. Volunteers providing services to the Utah State Hospital are allowed to operate state vehicles when the following conditions have been met:
 - 1.1 the volunteer has a current Utah State driver's license;
 - 1.2 has attended and successfully completed the Utah Defensive Driving course.
 - 1.3 has approval by the Unit Administrative Director or Unit Nursing Director and the Unit Volunteer Supervisor to use a state vehicle and to escort a patient off Utah State Hospital grounds.
2. Defensive driving courses are scheduled by contacting the Hospital Volunteer Coordinator.
3. Before a volunteer operates a state vehicle, a copy of the valid Utah State driver's license and Defensive Driving course completion certificate must be presented to the Hospital Director of Risk Management and to the Utah State Hospital switchboard operator by the Utah State Hospital Volunteer Coordinator. The switchboard operator will issue a PIN number to the volunteer.
4. The volunteer's Unit Supervisor will complete and submit a car request form to the Utah State Hospital switchboard. **Volunteers are not allowed to request the use of a state vehicle.** Only after confirming that the volunteer has completed the Defensive Course and has a valid Utah State Drivers license, will a vehicle be issued to the volunteer.

5. LDS Services, Catholic Services, or non-denominational volunteers will have the Utah State Hospital Volunteer Coordinator approve and request a state vehicle for their use.
6. State vehicles are used only for hospital business.

Initiated: 1-93
Reviewed: 9-95
Reviewed: 6-98
Reviewed: 3-02
Revised: 6-02

Chapter: ^{ci} Volunteer Services (VS)

Section 3: Ex-patients Serving as Volunteers

Policy

Utah State Hospital allows former patients to serve as volunteers at the hospital when it is beneficial to both the Utah State Hospital and the former patient.

Procedure

1. When a former patient is interested in being a volunteer at the hospital they first contact Volunteer Services to begin the process of becoming a volunteer. The patient is asked to sign a release allowing information about their case to be released to the volunteer services coordinator, executive staff, and other appropriate individuals.
2. Volunteer Services contacts the patient's former service management team (SMT) to request information as to the appropriateness of former patient working as a volunteer at the hospital.
3. Following the appropriate clearance by the SMT, the request is considered by the Executive Staff as to the overall appropriateness of the former patient being a hospital volunteer.
4. The ex-patient, once approved, is oriented and signs confidentiality forms as per volunteer protocols.
5. Once a former patient is approved to be a hospital volunteer their performance is evaluated on an ongoing basis with an official report being made to the Executive Staff after the first three months. The volunteer coordinator is responsible for this report in conjunction with administrative area where patient is serving.
6. Whenever a former patient is cleared to be a hospital volunteer they are placed in a situation where they are likely to have a successful experience.

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